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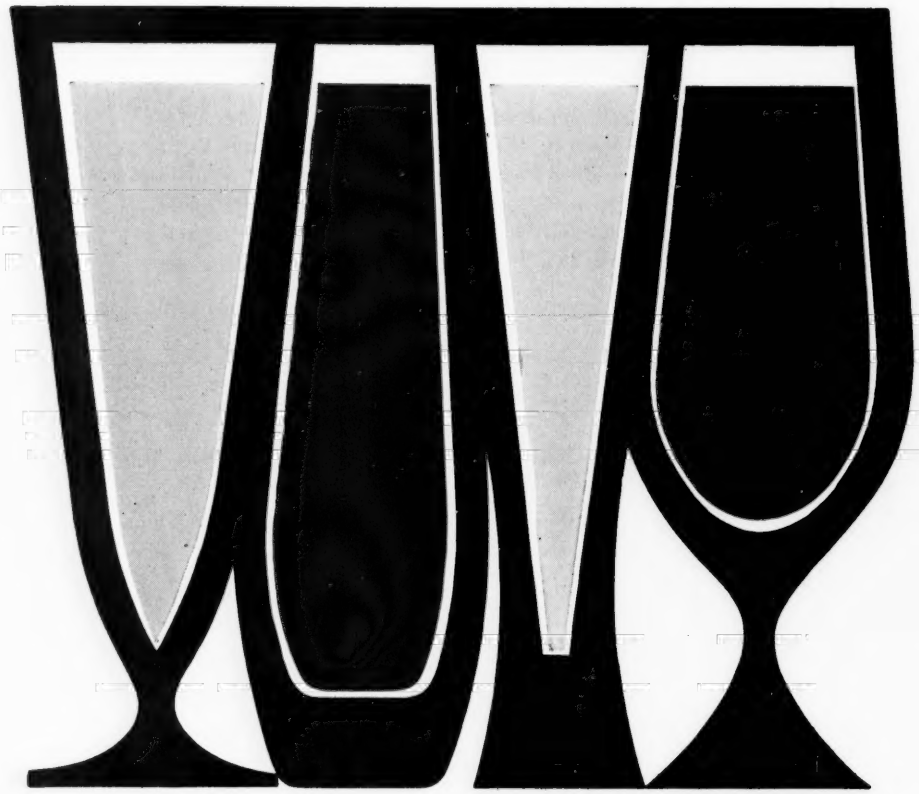

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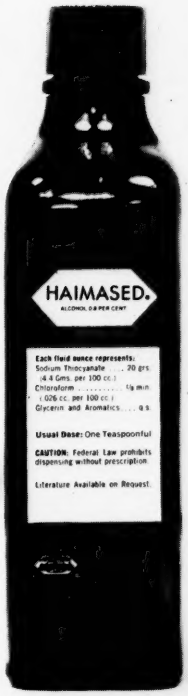

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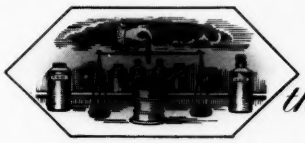

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AN INSURANCE ACTUARY VIEWS THE NATION'S SOCIAL SECURITY PROGRAM

THE TRUTH about this country's social security program has been distorted and misrepresented to the American people and "important political and economic consequences" may result when the facts are ultimately understood, according to an insurance actuary writing in the April 8 issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

The article, titled *The Coming Din of Inequity*, was written by Ray M. Peterson, vice president and associate actuary of the Equitable Life Assurance Society of the United States.

Peterson declared that:

1. The public is being given the false impression that the method of financing the social security program possesses many of the unique characteristics of voluntary private insurance which the people have learned to value highly.

2. The program has been misrepresented as being a "time-tested" and "tried and proved" system of financing old-age benefits.

3. The people are being given the mistaken impression that social security benefits are paid out of accumulated reserves, similar to private insurance programs, when in truth the program is financed almost entirely on a pay-as-you-go basis with benefits paid out of current income.

Peterson noted that "a great national debate is now in progress as to the issue of providing medical care and hospital benefits under the Social Security System."

"That debate," he said, "can be pursued intelligently and wisely only if we understand the true nature and implications of the social security financing mechanism."

He said that a national old-age pension program can be financed on a pay-as-you-go basis, a full-reserve basis, or some combination of the two.

Full-reserve financing is a "prepaid system" in which benefits are fully paid for during the years before they are received, he said.

"Full-reserve financing in the field of private insurance is the test of actuarial soundness and it is the only concept of actuarial soundness with which the American people are generally familiar," Peterson said.

He pointed out that under private insurance, all money paid into the insurance fund together with all income from investment is sufficient to pay all promised or guaranteed benefits.

Pay-as-you-go, on the other hand, means that the government raises through current taxes just enough money to pay the cost of benefits currently due, he said.

"No reserve is accumulated, no element of prepayment is involved," he said. "Money is raised as and after payees become eligible to receive benefits. In this latter sense, 'pay-as-you-go' is really a post-paid system of financing."

He added that the fiscal soundness of a government program depends "mainly on the taxing power of the government."

Peterson declared that the 80 per cent of social security taxes paid for the old-age pension portion of the program (20 per cent going to survivor and disability benefits) would buy for new entrants 40 to 60 per cent more in old-age benefits under an insurance company group annuity program.

He pointed out that from 1956 through 1965, tax collections for the program will total $115.1 billion while benefits and expenses in that period will total $114.5 billion.

"These figures clearly show that we are now almost completely on a 'pay-as-you-go' or 'hope as you pay' basis," he said.

He said the true nature of social security financing is also "vividly reflected" by the gap between the value of benefits owed to current beneficiaries and the amount of money in the trust fund.

If taxes paid into the fund had been stopped by Congress last year, Peterson said, the $20.2 billion in the fund would have paid only 23 per cent of the $88.3 billion of obligations to current recipients.

And if tax contributions are cut off in 1965, he said, the estimated $23.1 billion which will be in the fund will pay only 20 per cent of the $114.2 billion of benefit indebtedness owed to the then current beneficiaries.

There would be nothing left over for the millions who had paid taxes to the program but had not yet qualified for benefits, he said.

Peterson stressed also that young workers and those who enter the labor market in the future, together with their employers, will pay more in taxes than the workers will receive in benefits

because they must bear a growing burden of indebtedness. This indebtedness arises, he said, from the fact that most present workers and those now receiving payments will have contributed, together with their employers, a great deal less than the actual obligations.

He said there is a "dawning realization" that Americans have but one choice — to pay interest on this debt "forever" since the only way to reduce the debt is for a given generation to build up a huge reserve over and above present payments solely to meet program obligations. "To expect this to happen is to be politically and economically unrealistic," Peterson said.

He said the debt arising from these unearned benefits has climbed from $150 billion in 1952 to about $300 billion under the existing program. It will rise even higher, he said, if Congress adds to the program without a tax increase high enough, as to present workers, to meet the additional cost.

Peterson quoted several public figures who have likened social security to prepaid private insurance. These include President (then Senator) Kennedy who had called social security a system of paid up insurance and a way of saving money for old age so the elderly won't be a burden to their children.

He said there "is no foundation for these inaccurate parallels" with private insurance.

"Indeed, there is desperate need to dispel these self-mesmerizing, foggy concepts," Peterson said.

He pointed out also that "with no reserve fund in sight to reduce the debt" created under the social security program, "the burden being passed on to future generations is permanent. It is not something that will somehow work itself out, or go away; it is not an actuarial fantasy."

Peterson said that adding medical care to the Social Security System for the present aged would alter the original concept that each person must contribute for a minimum period of time before he is entitled to benefits.

Furthermore, he said, under the Administration social security program, or similar proposals, medical care would add between $20 and $30 billion to "the permanent social security debt on which future generations and their employers would need to pay interest forever."

Peterson said the main purpose of his article was to "show that there are excellent reasons for grave concern as to the probable ultimate effects of continued distortion and misrepresentation by interpreters of the Social Security Act, by statements of inadequately informed members of Congress and even by publications of the Social Security Administration itself."

Another purpose, he said, was to "set the record straight by portraying an accurate picture of the financing mechanism as now operating and by exposing the distortion and misrepresentation, no matter what its origin."

He said that when the American people finally learn that social security financing is "distinctly different" from voluntary private insurance with which it is compared, "a rude awakening may well occur, one which could have important political and economic consequences."

"Will the youngsters of the future protest what the oldsters of this generation have voted for themselves? During the decade ahead, will we oldsters, as we seek to enjoy our social security benefits, hear a rising clamor of unfairness — a din of inequity?"


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The RHODE ISLAND MEDICAL JOURNAL

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SOME BIOCHEMICAL ASPECTS OF PSYCHIATRY*

MARK D. ALTSCHULE, M.D.

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MOST OF THE DRUGS recently introduced for the treatment of mental and emotional disorders affect the metabolism or the activity of brain amines and their derivatives. Accordingly, it might be interesting to attempt to relate the clinical effects of the drugs to their actions on brain amines and on some of their derivatives.

The brain contains, among other things, (a) catecholamines such as norepinephrine, epinephrine, and dopamine; (b) serotonin and melatonin; (c) gamma-aminobutyric acid; (d) acetylcholine; (e) histamine; and (f) several small amines such as ethylamine and ethanolamine and also the piperazines (Figure 1). The specific functions of the various larger amines are only vaguely understood; these functions are believed to involve transmission of the nerve impulse. However, only in the case of acetylcholine is the role of the amine fairly well established; acetylcholine appears to play an important part in synaptic transmission. It is not surprising, therefore, that drugs that inhibit acetylcholine[1] and also those that increase its concentration by inhibiting cholinesterase[2,3] induce psychotic behavior in both animals and man. These apparently discordant observations are not really so; they suggest that either too much or too little of the neurohumors in the brain may give rise to manifestations of what has been poorly named "mental disease." The clinical significance of these experimental data is well known; psychiatric symptoms are among the toxic effects of such drugs as atropine. The fact that reserpine increases the acetylcholine content of most parts of the brain[4] cannot at the moment be related to any clinical change that the drug produces, and consequently it is ignored by most workers who are interested in establishing one theory or another.

The finding of catecholamines in the brain has stimulated much interest. Relatively large amounts of dopamine — the precursor of epinephrine and norepinephrine — are found, but this amine is generally regarded as having little pharmacologic activity. The other two, epinephrine and norepinephrine, are more interesting for several reasons: (a) giving these substances intravenously in small doses produces anxiety, the onset of which is accompanied by electroencephalographic evidence of activation of the reticular activating system;[5] (b) the reticular activating system contains considerable amounts of catecholamines, and injecting epinephrine strongly stimulates the reticular activating system,[6] which regulates awareness, among other things; (c) some derivatives of epinephrine produce depersonalization, delusions, and hallucinations when injected. Accordingly, the effects of various drugs on catecholamine distribution and metabolism may have some bearing on the manner in which these drugs produce their clinical effects.

Tranquilizing Drugs in Neurosis

Depletion of body stores of catecholamines. Drugs of the reserpine group deplete the brain[7,8,9,10,11] and the adrenal medulla[7,8,12] of catecholamines. Depletion of the brain's catecholamines may be expected to diminish the hyperawareness that characterizes many neurotic patients. In addition, the fact that reserpine and related drugs deplete the adrenal medullary stores of epinephrine suggests that patients who are under the influence of these drugs might respond to physical and emotional stresses by pouring out less than the usual amount of catecholamines, and might thereby experience less anxiety than previously. It should be noted that during the period in which catecholamines stores are being depleted, the blood epinephrine concentration is greatly elevated;[13] accordingly, an increase of some psychiatric symptoms may occur initially. This temporary exacerbation has actually been observed clinically.

continued on next page

*Presented at a meeting of the Providence Medical Association held at the Rhode Island Medical Society Library, Providence, Rhode Island, November 7, 1960.

These data on anxiety have nothing to do with the possible role of catecholamines with respect to mood; this is discussed below.

Chelation of catecholamines. The phenothiazines, in common with other sulfur-containing organic compounds, apparently chelate catecholamines. The hypotension that the phenothiazines produce when given in large amounts is probably due to this phenomenon. Meprobamate also produces hypotension when given in excessively large doses; its structure includes two NH_2-C^1=O groups that may likewise chelate epinephrine. The chelation of catecholamines might be just as useful a change as the depletion of body stores of these amines that was discussed above.

Accelerated destruction of epinephrine. Three drugs that are used in the treatment of psychiatric disorders accelerate the destruction of epinephrine; these are chlorpromazine, reserpine, and imipramine.[14] The anxiety-allaying actions of the first two might be potentiated by this phenomenon. However, it is difficult to understand how the phenomenon might contribute to the effects of imipramine.

Depression of the reticular activating system. Available data indicate that the tranquilizing drugs depress the reticular activating system. It is not clear whether this is owing to their effects on brain catecholamine concentrations or to some other action. At any rate, this effect should cause sedation and a diminution of the hyperawareness that is so troublesome in neurotic patients.

Depression of conditioned responses. The tranquilizing drugs prevent the formation or the carrying out of conditioned responses.[15,16,17,18] Unfortunately, the possible significance of conditioned responses in psychiatry has been almost completely ignored; therefore no statement can be made about this effect of tranquilizer drugs.

Some authors have attempted to relate the sedative effect (not the anxiety-allaying effect) of reserpine to the fact that it depletes brain catecholamine levels.[39] However there is no absolute correlation between the levels of brain catecholamines and the occurrence of sedation.[40] On the other hand, it is possible that some tranquilizing drugs — that is, the phenothiazines, which do not deplete the brain of catecholamines — may nevertheless block their action.[41]

In general, the known effects of the three main groups of tranquilizing drugs indicate that the compounds should be useful in moderating the feeling of anxiety and the hyperawareness found in neurotic patients. However, it is well known that allaying these symptoms in patients with severe neurosis does not significantly improve the general clinical status. (It might be pointed out parenthetically that the expectation that any anxiety-allaying drug will cure neurosis is based on a misconception of the nature of neurosis;[19] this misconception is based on the uncritical acceptance of Freud's unsubstantiated opinions about the disorder.) Accordingly, relying on these drugs alone to treat neurosis is certain to lead to disappointment in many cases.

Serotonin has been the object of much discussion, even though little is known about its functions in mammalian physiology. It is known, however, that reserpine and related compounds cause a decrease in the amount of serotonin in the brain.[8,9,11,20,21] Some authors have attempted to relate the sedative action of the reserpine group of tranquilizing drugs to this phenomenon. However, it now appears that the decrease in brain serotonin concentration follows rather than precedes the onset of sedation.[11] Moreover, in some types of experiment an increase of brain serotonin content is accompanied by sedation.[22] The data indicate that changes in brain serotonin levels cannot account for the sedative effects of reserpine. The role of serotonin in neurophysiology is still a mystery.

The fact that large amounts of histamine are found in the midbrain provides another mystery; its function in that area is completely unknown. The facts that some phenothiazines have antihistaminic effects and that reserpine depletes body stores of histamine[23] merely serve to tantalize the neurophysiologist, who is left with the conviction that there must be some meaning in all these observations — a meaning that so far has eluded detection.

Effects of Tranquilizing Drugs in Schizophrenia

Phenothiazines and the reserpine group of compounds have proved useful in the treatment of schizophrenia. About 15 or 20 per cent of patients with the chronic disease show enough improvement when given these drugs to be able to do without hospitalization. Schizophrenia is a disease in which certain disorders of indole metabolism occur, with resultant accumulation in the body of some substances known to cause depersonalization, delusions, and hallucinations and of other substances suspected of having these effects.

Aminochromes. Certain indoles that can be made either from catecholamines or from their precursors (Figure 2) accumulate in the blood of schizophrenic patients.[24] They are called aminochromes because they are colored: adrenochrome, which is brown; adrenolutin, which is yellow; etc. Spoiled epinephrine turns yellowish-brown and acquires hallucinogenic properties.[25] The exact source of the aminochromes in schizophrenia is not known, nor is the precise mechanism that leads to their formation in this disease. One hypothesis concerning the favorable effect of reserpine in schizophrenia is that the drug, because it is an indole (Figure 3), becomes

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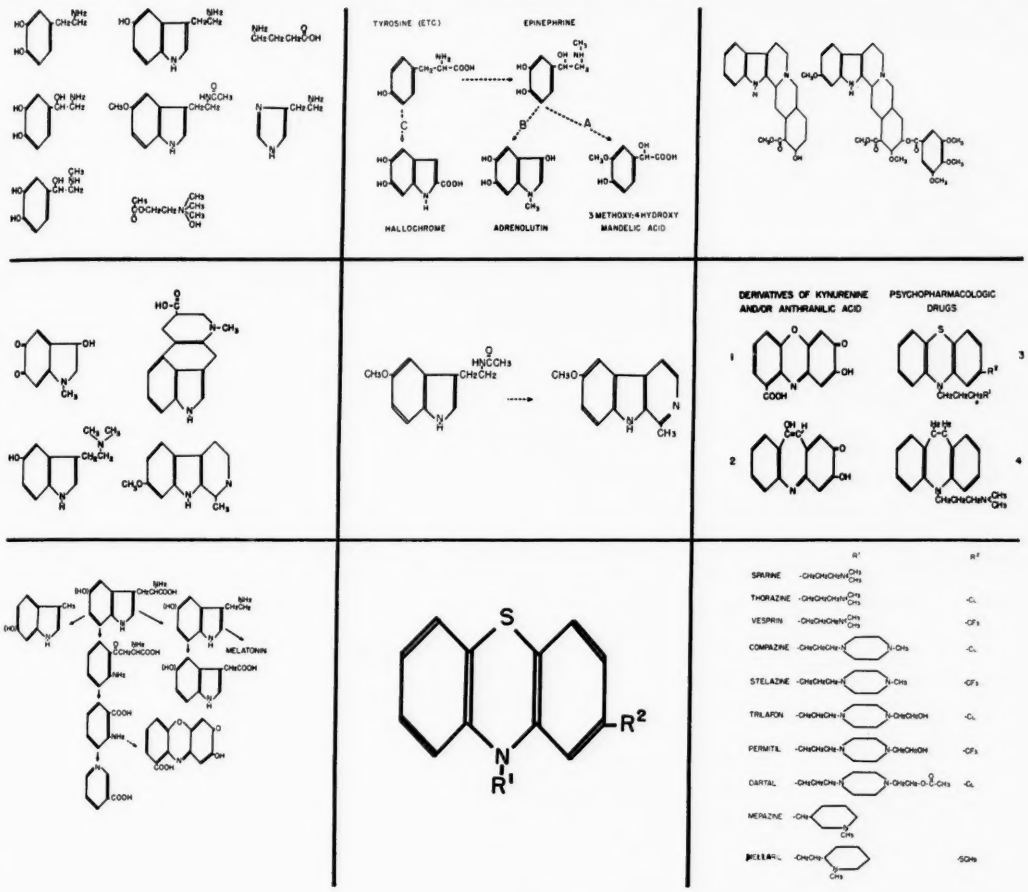

FIGURE 1

Upper left. Some amines found in brain. At the left, from top to bottom, are dopamine, norepinephrine and epinephrine. In the center are serotonin, melatonin and acetylcholine. At the right are gamma-aminobutyric acid and histamine.

FIGURE 2

Upper center. Aminochromes may be derived either from epinephrine (adrenolutin, etc.) or from epinephrine-precursors (hallochrome, etc.).

FIGURE 3

Upper right. Reserpine at the right is an indole related to yohimbine at the left.

FIGURE 4

Middle left. Some indoles currently under investigation. At the left are adrenochrome above and bufotenine below. At the right are lysergic acid above and harmine below. Adrenochrome is a saturated indole and is not hallucinogenic. The other three are unsaturated and are hallucinogenic.

FIGURE 5

Middle center. Transformation of melatonin to a harmine-like compound.

FIGURE 6

Middle right. Similarities between ommochromes at the left and, at the right, phenothiazines (above) and imipramine (below).

FIGURE 7

Lower left. Metabolism of tryptophane. The kynurenine pathway in the center ordinarily leads through anthranilic acid to nicotinic acid. However, as shown by the dotted arrow which veers to the right, ommochromes might possibly be formed also.

FIGURE 8

Lower center. (A) The phenothiazine nucleus.
Lower right. (B) The side-chains in various drugs.

SOME BIOCHEMICAL ASPECTS OF PSYCHIATRY

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bound to certain sites on brain proteins, thereby preventing the attachment of indoles such as aminochromes that might poison enzymes. This concept is purely speculative, and there is no evidence for (or against) it at present.

Harmine-Indoles. Harmine is known to be one of the hallucinogenic indoles (Figure 4). McIsaacs has recently suggested that one of the neurohumors, melatonin, might be changed to a harmine-like indole (Figure 5). This transformation is easily accomplished *in vitro* but has not yet been demonstrated *in vivo*. Reserpine consists of a harmine-like nucleus to which other groups are attached (Figure 3). It is therefore possible that the above-described speculative explanation of the action of reserpine in counteracting the effects of aminochromes might also apply to any harmine-like derivatives of melatonin formed in the body.

Ommochromes. Ehrensvard[27] recently called attention to the similarities of structure between certain derivatives of tryptophane and some drugs used in psychiatric practice (Figure 6). The occurrence of these so-called "ommochromes" has not yet been shown in schizophrenia; accordingly, any discussion of their role in this disease must be speculative. A large proportion of ingested tryptophane is oxidized to kynurenine, then to anthranilic acid, and then to nicotinic acid (Figure 7). However, the ability to oxidize anthranilic acid appears to be impaired in schizophrenia.[27] Under certain circumstances the accumulation of anthranilic acid leads to the conjugation of this compound to form ommochromes (Figure 7). If this does happen in schizophrenia, administered phenothiazines would preempt sites on brain proteins that might otherwise be occupied by ommochromes. The commercially available phenothiazines all have a central nucleus that resembles an ommochrome except that phenothiazines contain sulfur at the place in the molecule where ommochromes contain oxygen (Figure 5); the various phenothiazines on the market differ only with respect to their side-chains (Figure 8).

Of the various abnormal nitrogenous compounds believed to accumulate in the blood of schizophrenic patients, only the aminochromes have actually been shown to occur; the presence of harmine-like indoles and of ommochromes has yet to be demonstrated.

Brain Amines and the Mood

Some years ago the observation was made that apathetic tuberculous patients given isoniazid became less apathetic. This observation led to studies of the effects of iproniazid (Marsalid) and the subsequent development of a number of chemically-related compounds called "psychic energizers." (The idea that there is any such thing as "psychic energy" seems to have originated in the brain of the well-known German psychologist Herbart a century and a half ago; Freud borrowed the idea — neglecting, as usual, to acknowledge its source — and its present popularity is owing largely to Freud's writings.) All the currently used so-called psychic energizers except one are hydrazines; that is, they contain a –N–N– group. The one exception is imipramine (Tofranil) (Figure 6). Iproniazid and similar compounds inhibit the enzyme monoamine oxidase and thereby interfere with the oxidation of epinephrine and norepinephrine and also of serotonin. Inhibiting the action of the enzyme leads to a considerable increase of brain serotonin.[22,28,29,30] Some authors have attempted to relate the so-called "psychic-energizing" effects of the drugs here discussed to this change, but this concept is negated by the fact that at least one type of monoamine-oxidase inhibitor causes sedation even though it increases brain serotonin concentration.[22]

Other authors have attempted to relate the so-called "psychic-energizing" effects of the hydrazine drugs to accumulation of catecholamines in the brain. However, the first step in the destruction of these amines is the attachment of a methyl group to form metanephrine and normetanephrine, compounds that are pharmacologically and psychologically inert. Therefore, although the so-called "psychic energizers" impair the oxidation of catecholamines,[31,32] they cause the accumulation of metanephrine and normetanephrine;[31,33] the amount of epinephrine that is excreted unchanged does not increase[34] and the effect of administered epinephrine is changed little if at all.[35,36,37] Moreover imipramine is not a monoamine-oxidase inhibitor, and it actually accelerates the destruction of epinephrine;[14] nevertheless, it is an excellent drug to use in depressions.

The available evidence therefore indicates that there is no relation between the monoamine-oxidase inhibiting effect of the so-called "psychic energizers" and their clinical effects. Iproniazid (Marsalid) is known to depress the action of diamine oxidase, the enzyme partly responsible for the metabolism of histamine,[35] but there is nothing to suggest that this explains the clinical effects of this drug. On the other hand, recent studies show that drugs of this type — that is, those that contain an –N–N– group — depress the synthesis of gamma-aminobutyric acid.[38] Gamma-aminobutyric acid is believed to act as an inhibitor of transmission of brain impulses; therefore this biochemical effect of these drugs may account for their clinical effects. However, it is evident that much remains to be done in this field. Nevertheless, it is also evident that referring to the drugs in this group as monoamine-oxidase inhibitors, although it is not inaccurate, is misleading with respect to the mechanism of their action.

Conclusions

Study of the pharmacologic and biochemical changes caused by various drugs used in the treatment of psychiatric symptoms provides information on which to base understanding of some of their clinical effects. For the most part, however, relations between biochemical changes and clinical effects are speculative; in some cases the currently assumed relations are based on erroneous interpretations of available data.

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THE RELATIONSHIP BETWEEN BRONCHIOLITIS AND ASTHMA IN INFANCY

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BRONCHIOLITIS, also called capillary bronchitis and asthmatic bronchitis, is a common disease in infancy, especially in the first six months of life. It may be described as a respiratory infection, presumably of viral origin, usually occurring two or three days after the onset of a cold, and having symptoms of obstructive emphysema, such as wheezing and dyspnea. The pathology is that of bronchitis with, in some instances, areas of atelectasis and pneumonitis.

It is important to emphasize that in bronchiolitis there is obvious obstruction and difficulty in expiration, with wheezing and musical noises or rales in the chest. We are not discussing the respiratory infections of infants with pneumonia-like symptoms of rapid breathing, grunting, and high fever. Although there seems to be a tendency for those babies under six months of age with an asthmatic element in their constitution to have respiratory infections of an unrecognizable type, these cases are not under discussion.

We are advancing the thesis that the signs and symptoms of bronchiolitis are produced most frequently in babies having by inheritance a liability to asthma. A respiratory infection in such babies tends to cause edema and secretion in the smaller bronchi with resulting obstructive emphysema. The pathology of infectious asthma in older children as well as in infants is not well understood, but there seems to be a similarity between this and bronchiolitis. Probably the relationship of bronchiolitis and asthma in infancy often is not recognized in hospital practice, because the asthmatic baby is less often seen repeatedly in the hospital than he is in private practice.

Bronchiolitis and infectious asthma in infancy have characteristics in common. There is obstructive emphysema, usually a slight fever below 101°, and little or no leucocytosis. There is little obvious benefit from antibiotics; the attack tends to last two or three days with or without medication. Adrenalin gives some relief, but not very much, and the relief is transient. Before the age of six months, there is often respiratory difficulty without prolonged expiration and musical wheezing.

Literature

There are many reports in the medical writings that indicate a relationship between bronchiolitis and asthma. Many writers, especially in Europe, use the term asthmatic bronchitis instead of bronchiolitis. Bray[1] speaks of the acute bronchitic form of asthma in infancy. He states that in a large series of cases, including his own and those of other writers, it was found that in the asthma of children 23% of the cases begin before the age of one year, and 17% during the second year. These figures must include many patients that others would consider to be bronchiolitis or asthmatic bronchitis.

Köhler and Mai[2] in 1927 reported on the relationship between the spastic bronchitis of infancy and true bronchial asthma. They found that, of 86 infants with spastic bronchitis, 62% had a family history of asthma and "other disease of its kind." (Quotation from my translation.) A control group had a similar family history in only 22%. They also found that ten of these 86 infants were known to have developed true asthma later. Cooke[3] describes asthma and asthmatic bronchitis in infancy, and considers it infectious and due to infection alone.

Wittig and Glaser[4] have reported that in three Rochester hospitals over a period of seven years there were one hundred cases of bronchiolitis that could be followed; thirty-two of these patients were later found to have asthma. This last observation would seem to be conclusive evidence that there is some relationship between bronchiolitis and asthma at least in some cases.

Personal Experience

I have tried to explore this problem from the other end and find out what evidence there is of "bronchiolitis" preceding known cases of asthma. I have in my files the records of 144 babies whom I have seen before the age of two with asthma. These records were kept in the normal course of caring for these babies, and the description of a first attack or a preceding infection is often not as explicit as would be desirable for the purposes of this study.

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EXPERIENCES WITH HUMAN TUMOR VACCINES*

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FOR OVER FIFTY YEARS investigators dealing with the problems of cancer therapy have been intrigued with the possible application of immune mechanisms to the treatment of this group of diseases. Attempts to immunize an individual against his own tumor have been based on the hypothesis that a tumor is in some way antigenically different from the host and that host resistance can be increased against the specific tumor. It has been postulated that some of the apparent spontaneous remissions of far advanced cancers have been due to naturally developing increased host resistance. The currently popular concept of "biologic predeterminism" in relation to a specific cancer in a specific host is also in part based on the theory that each host reacts in a different way to a specific tumor and that the individual variations in tumor growth and spread are in part due to host resistance.

In August of 1959 Doctors Graham and Graham of the Roswell Park Memorial Institute in Buffalo, N.Y., reported a series of patients with far advanced cancer who had been treated with vaccines made from their own tumors.[1] The vaccine in each instance consisted essentially of a mixture of the patient's tumor in cellular suspension mixed with Freund's adjuvant. The addition of adjuvant in making the vaccine was based on laboratory studies which had shown that the immune response to a standard antigen was twenty times greater when the antigen was mixed with the adjuvant when compared to the antigen alone.[2] The series of patients reported by the Grahams consisted mostly of patients with far advanced gynecological cancers. It was their opinion that the vaccines might have had a beneficial effect in their series of patients, and that they possibly had an effect in potentiating the therapeutic effectiveness of radiation. They reported no serious complications to the use of the vaccine. Subsequent direct communication with Dr. Ruth Graham, and a visit to her laboratory were of much help in determining the proper method of making the vaccine. Since it was probable that vaccine therapy would have no untoward effect in seriously ill patients with very poor prognosis, and since the Grahams had indicated that the vaccine might have a potentiating effect on radiotherapy, it was concluded that it would be worth while to pursue a trial of vaccine therapy in patients with far advanced bronchiogenic carcinoma. We were encouraged to undertake this work by Dr. Ruth Graham, who felt that theoretically such patients could be benefited. The study here reported is based on a series of seventeen patients who were treated with autogenous tumor vaccines between September, 1959 and July, 1960. Of this group three patients were treated for carcinoma of the ovary. The remaining fourteen had far advanced bronchiogenic carcinoma.

The patients with carcinoma of the ovary will be discussed first. Of these three all had far advanced cancer with metastasis at the time the vaccine was given. Two of the patients had recurrent carcinoma and the tumor was obtained at a subsequent laparotomy. The first patient to receive vaccine had a recurrent far advanced carcinoma of the ovary eight years after the original diagnosis had been made. She had remained asymptomatic during this period. Vaccine was administered in August, 1959 and was followed by a course of X-ray therapy. This patient had extensive perirectal involvement with almost complete rectal obstruction due to tumor. Following administration of the vaccine it was possible to cancel plans which had been made for a colostomy since the tumor diminished in size sufficiently to relieve the obstruction. It is of interest that the tumor in the rectal area was outside the field of the X-ray therapy. The patient survived for over a year after the procedure was performed and died in August, 1960. In the second patient, far advanced ovarian carcinoma was established at laparotomy; in October, 1959 she was given vaccine therapy. This was followed by radioactive cobalt therapy. The patient expired eleven months later.

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*Presented at the First Annual Research Project Evening of Miriam Hospital, Providence, Rhode Island, April 17, 1961.

The third patient was found to have recurrent ovarian carcinoma at repeat laparotomy in November, 1959 one year after the original diagnosis. Vaccine was administered without additional X-ray therapy. This patient is still alive and apparently well without tumor recurrence fifteen months after administration of the vaccine.

The remaining fourteen cases all had far advanced lung carcinoma diagnosed at thoracotomy and confirmed by pathological report. In the majority of these patients the vaccine was made with the original tumor, while in a few metastatic supraclavicular lymph nodes were utilized as source of tumor material. Of the entire group of fourteen patients two expired in the hospital with complications which were attributable to the surgery. One patient, who received a vaccine made with what was felt to be an inadequate amount of tumor material obtained from a small supraclavicular node, expired less than one month after the administration of the vaccine. Of the eleven determinate cases three are living more than one year. All of these received postoperative radioactive cobalt therapy. Of the remaining group of patients four died within three months after the institution of therapy. Of these, one received additional radioactive cobalt therapy. Four lived for three to six months and of this group one received nitrogen mustard and three radioactive cobalt therapy. Although the results with this small group of patients appear far from striking it is worth noting that all of these patients had far advanced disease and all had a very poor prognosis at the time the vaccine was administered. Three of the carcinoma of the lung group survived for more than one year giving a survival rate of 27 per cent for the determinate group, and 21 per cent for the entire group. Of the ovarian carcinoma group one of three is living fifteen months after laparotomy and vaccine therapy. No untoward sequelae were encountered as a result of vaccine therapy, although in most patients sharply defined ulcerations developed on the anterior thighs at the side of administration. In no patient was tumor implant in the subcutaneous tissues encountered although cellular suspensions of tumor were injected. It is felt that the brisk local reaction including ulceration at the site of vaccine injection represents host response to the tumor, and it was considered to be an encouraging sign when such reactions appeared.

Conclusion

Although the results obtained with autogenous tumor vaccines have not been dramatic, it is felt that our experiences to date and those reported by other investigators warrant further trials with this material, particularly in combination with X-ray therapy.

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RELATIONSHIP BETWEEN BRONCHIOLITIS AND ASTHMA IN INFANCY

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Even so, at least thirty-one, or twenty-one per cent, of the babies had as their first symptom a respiratory infection, seven of these were sent to the hospital with this first attack, and seven more were diagnosed as pneumonia without any statement about hospitalization. This study is further complicated by the fact that most asthmatic attacks in infancy occur with an infection and most asthma in infancy seems to be of the infectious type. If careful histories are taken, it will in all probability be demonstrated that in infancy the first attack usually occurs with a severe respiratory infection. In my last six cases in which the history was taken with this study in mind, this was the case.

The asthmatic constitution in an individual varies in degree. At one extreme is the baby whose father and mother both had asthma, who has eczema and continuous asthma, and who has large positive skin tests including that to egg. At the other extreme is the baby with no allergy in the immediate family, with no eczema and no positive skin tests, whose constitution may be shown only by three or four attacks of infectious asthma. The characteristics of patients vary between these two extremes. Of my patients, about one-third had no signs of allergy except for the recurring attacks of wheezing. However, the recurring attacks of wheezing seemed to be exactly the same (except for severity) in the obviously allergic patients and in those with no other signs of allergy.

SUMMARY

It seems probable that a respiratory infection in a baby with an asthmatic tendency produces obstructive emphysema. So-called bronchiolitis is usually a manifestation of this process. This is of more than academic importance; if the physician is on guard to watch for beginning asthma, he can do something to help prevent the development of this serious condition.

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AN APPRAISAL OF INTRA-ARTICULAR PHENYLBUTAZONE

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THE EFFICACY of intra-articular hydrocortisone and its newer analogues in relieving active arthritis in individual joints is well known.[1] That this form of treatment has decided limitations is also recognized, e.g.: (1) The symptomatic relief may be transient, or of relatively short duration. (2) Refractoriness to the agent may develop, and activation of latent, or unrecognized tuberculous synovitis may develop.

This study was undertaken to determine if results comparable to steroid instillation could be obtained in (a) patients unresponsive, or refractory to the latter, and (b) untreated cases; and to determine any possible local or systemic side effects.

The material used was a 20% solution of phenylbutazone.* Amounts used were 2 cc. for paracentesis of the hip; 1½ cc. for other joints, except digital, where ½ cc. was used.

The type of arthritis previously documented by history, physical examination, X rays, and laboratory studies is indicated in Table 1. Twenty rheumatoid patients were treated, evenly divided as to sex. A total of twenty injections in this group were given. Twenty-five osteoarthritic patients were treated; in this group there were twenty-three females and two males. The average age in the rheumatoid group was 52.5 years male, and female 36.6 years. The case of longest duration was a female osteoarthritic of twenty years and the case of shortest duration was a female rheumatoid arthritic of eleven months. The oldest case was an eighty-year-old female and the youngest a seventeen-year-old male. In the osteoarthritic group the averages were 64.5 and 67.5 years respectively. One male gouty patient was treated.

The subjects of this study were outpatients of the Medical Arthritis Clinic of St. Joseph's Hospital, Providence, Rhode Island.

*Supplied by the Geigy Pharmaceutical Company of Ardsley, N.Y.

The severity of arthritis in a particular joint was graded as follows: (Grade 1) Bony changes by X rays, but only stiffness and aching after prolonged stress. (Grade 2) Moderate intermittent aching and swelling, occurring even at rest. (Grade 3) Active persistent inflammation and effusion, with increased temperature, but still functional ability. (Grade 4) "Red hot" joint, with severe inflammation, and little function.

TABLE 2
Total of Joints Injected

Knee	30
Hip	5
Ankle	1
Shoulder	5
Elbow	1
Interphalangeal	2
Wrist	2
	46

Only one injection in any joint was given.

Results

Improvement was graded on a percentage basis, in terms of relief of pain and improvement in heat, swelling, tenderness, and ability to use joint actively. Any improvement (25% or better) lasting twenty-four hours was considered significant. Only seven patients showed significant improvement. Four of these were rheumatoid; including two of the knee, one proximal interphalangeal, and one shoulder joint. The remaining three cases had osteoarthritis of the knee; two showed 25% improvement for two weeks; the third 50% improvement, lasting seven weeks. All of these cases were rated Grade 2 in severity.

No serious side effects were encountered. Three patients complained of slightly increased pain in the injected joint for twenty-four hours.

Discussion

This was a purely clinical study. No attempt was made to evaluate improvement or regression by means of serial synovial fluid analyses or X rays; nor were control medications or placebos used in improved cases. Improvement was assayed purely on patients' subjective response, increased range of motion, and physical examination of the involved joint as regards heat, swelling, and tenderness. It is of interest that in four of the cases improved by this treatment previous hydrocortisone injections had

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TABLE 1

(a) Females

Name	Type	Joint	Result	Previous Treatment	Comparison with Hydrocortone Injections
J. D.	R.A.	Knee	100% improvement	Steroids Salicylates	Better
E. C.	R.A.	Knee	No signif. change	Steroids Gold salts	Hydrocortone better
M. R.	R.A.	3rd Prox. interphal.	50% improv. in pain & motion for 5 wks.	Steroids Salicylates	No H. C. inj.
J. S.	R.A.	Hip	25% improv. in pain for 2 wks.	Steroids Physical therapy	H. C. better
C. R.	R.A.	Knee	10% improv. in pain for 2 wks.	Steroids Physical therapy	H. C. better
G. D.	Mixed	Knees	Questionable improvement	Steroids Physical therapy	Equivocal
R. V.	Mixed	Knees & shoulder	10% improv. in pain & stiffness	Steroids Salicylates	H. C. better
N. S.	Osteo.	Knees	25% improv. in pain, 15% in motion for 2 wks.	Salicylates	H. C. better
M. C.	Osteo.	Knee	No signif. change	No previous treatment	No H. C. inj.
F. S.	Osteo.	Knees	25% improv. in pain & motion for 2 wks.	Steroids Physical therapy	H. C. better
A. V.	Osteo.	Knees	No signif. change	Steroids Physical therapy	H. C. better
M. B.	Osteo.	Knee	No signif. change	Salicylates	H. C. better
M. Be.	Osteo.	Hip	No signif. change	None	Equal
M. P.	Osteo.	Hip	No signif. change	Salicylates	No H. C. inj.
M. A.	Osteo.	Knee	No signif. change	Salicylates	No H. C. inj.
M. Ab.	Osteo.	Knee	50% improv. in pain, 33% improv. in motion for 7 weeks	Steroids Salicylates	No H. C. inj.
M. O.	Osteo.	Elbow	No signif. change	Steroids	Equal
C. F.	Osteo.	Knee	No signif. change	None	No H. C. inj.
M. D.	Osteo.	Knee	No signif. change	None	No H. C. inj.
D. P.	Osteo.	Knee	No signif. change	None	No H. C. inj.

given at least as good relief, if not better. In view of this, and as similar contraindications for arthrocentesis exist for both drugs, it would seem that phenylbutazone has little practical advantage over hydrocortisone.

SUMMARY

Intra-articular phenylbutazone afforded significant improvement in seven patients of a total of forty-six. Three of these were osteoarthritics of long duration and of moderate severity. Four rheumatoid arthritics of moderate severity and long duration were benefited. No serious local or systemic side effects were noted.

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TABLE 1

(b) **Males**

Name	Type	Joint	Result	Previous Treatment	Comparison with Hydrocortone Injections
F. W.	R.A.	Knees	75% improv. in pain for 6 hrs.	Steroids Gold salts	Equivocal
R. F.	R.A.	Knee	33% improv. in pain for 2 wks.	Steroids Gold salts	H. C. better
J. L.	R.A.	Wrist	10% improv. in pain for 1 week	Steroids Physical therapy	H. C. better
G. D.	R.A.	Shoulders	75% improv. in pain for 2 wks.	Colchicine	Better
J. S.	Osteo.	Terminal interph. finger	No signif. change	Physical therapy	H. C. better
E. R.	Gout	Knee	No signif. change	Steroids Physical therapy Colchicine	No H. C. inj.
S. D	Mixed	Ankle	No signif. change	Steroids	H. C. better

PENNSYLVANIA ADJUDICATION ON BLUE SHIELD RATE INCREASES

On February 2, 1961, Honorable Francis R. Smith, Insurance Commissioner of the Commonwealth of Pennsylvania, handed down an adjudication on allowing certain increases in Blue Shield subscription rates.

In that same adjudication, the Insurance Commissioner stated that he was deferring action upon Blue Shield's request for increases in a number of the fees set forth in the Blue Shield fee schedule, and for the addition of various new benefits for that fee schedule. The Insurance Commissioner indicated, in this connection, that he desired additional data and information before taking action on these matters.

On February 2, 1961, the Insurance Commissioner disapproved a proposed Blue Shield Senior Citizens filing and in his adjudication disapproving such filing, made specific suggestions for the resubmission of this filing at the earliest practicable time.

THE FOLLOWING are excerpts from this adjudication:

Order of Insurance Commissioner

Accordingly, pursuant to the powers placed in me as Insurance Commissioner of Pennsylvania, under Section 12 of the Nonprofit Medical, Osteopathic and Dental Service Corporation Act, I hereby direct the Medical Service Association of Pennsylvania to undertake a study of its policies, contracts, fee schedules and powers, with the object of determining in what manner and in what specific respects it can legally take positive action to lessen any unnecessary utilization of Blue Shield benefits.

1. More specifically, I direct that it enter into discussions with the Pennsylvania Blue Cross Plans and representatives of the Medical Society of the State of Pennsylvania, and county medical societies for the purpose of determining wherein and in what manner Blue Shield can co-operate in the work now being performed by such agencies in endeavoring to lessen unnecessary hospital utilization, through review committees, admission committees and otherwise. Upon the conclusion of such conferences, Blue Shield can then submit to its legal counsel the proposed methods of co-operation to determine their specific legality under the law of this state. Such discussions and conferences in themselves which may bring about large areas of co-operation cannot, by any definition, be regarded as restrictive of a doctor's right to determine his own methods of diagnosis or treatment.

2. I further direct Blue Shield to initiate discussions with doctors and representatives of medical societies (and other interested groups) to determine in what manner the great amount of statistical records in the possession of Blue Shield, or which can be assembled by Blue Shield, can be used and made available to participating doctors for the purpose of casting light on any areas of possible over-utilization of Blue Shield benefits. In such discussions, consideration should be given to the establishment of a co-operative program designed to encourage doctors to lessen any such over-utilization of Blue Shield benefits. Any co-operative program developed through such discussions can be reviewed by Blue Shield's legal counsel to determine its legality under the applicable laws of this state.

3. I further direct Blue Shield to co-operate with state and local medical societies, hospital medical staffs, and other interested groups in encouraging the establishment of admissions committees in all Pennsylvania hospitals where Blue Shield subscribers may receive treatment.

4. I recommend that Blue Shield establish, as part of its internal organization, a utilization division with the function of carrying out the foregoing directives. In order to facilitate the establishment of this division and its effective operation, I hereby authorize Blue Shield to expend general reserve funds in a reasonable amount for this purpose.

5. I further direct Blue Shield to review its contractual provisions with subscribers and participating doctors and its fee schedules to determine whether or not modifications, deletions, or additions can be made which would tend to discourage any unnecessary utilization of Blue Shield benefits.

6. I also direct until further notice that Blue Shield submit to the Insurance Department quarterly reports, in written form, summarizing its activities under these directives.

Doctors' Fee Schedules

With respect to the fee revisions requested in this Filing, I shall therefore defer action pending additional substantiating data from Blue Shield.

In resubmitting any of these fee schedule revisions to me and in the submission of any revisions in the future, I recommend that Blue Shield consider the following factors in making such revisions and be prepared to demonstrate to the Insurance Department the effect of such factors upon each revision which it proposes:

1. Time and skills involved in the procedure being revised in relation to comparable procedures.

2. The average fees paid doctors in Pennsylvania for the procedure being revised and the average fees paid for comparable services in terms of time and skill.

3. The aggregate fees paid by Blue Shield to doctors for the procedure being revised and the number of doctors receiving such aggregate payment.

4. Comparable data relating to fees for similar services paid by public agencies such as the United States Veterans Administration to Pennsylvania doctors.

5. Data showing the aggregate instances where the revised fee will be in full payment for the procedure and data showing the aggregate instances where doctors will bill patients for additional amounts together with aggregate estimates of such additional billings.

6. The estimated average income (and basis of estimation) of the Blue Shield subscribers directly affected by such revised fee.

7. The submission of a formula, factor, or explanation showing to what extent the proposed fee is less than the average or reasonable fee for the same procedure which would properly be charged over income patients.

8. Such other data as will enable me to determine the reasonableness of such proposed revision.

The submission of future fee revisions to me on the foregoing basis will assist me in determining whether such proposed revisions should or should not be approved by me, as Insurance Commissioner.

A comprehensive review of all Blue Shield fee schedules taking into consideration the above factors is in order.

Blue Shield Benefits

In fulfilling my obligation to see that the objects and purposes of the Blue Shield Regulatory Act are being served, I request that Blue Shield consider the feasibility of extending full-service benefits to greater numbers of our citizens.

Testimony submitted at the hearing by Blue Shield representatives shows that existing fee schedules are adequate to cover 82% of doctors' normal charges. There was further testimony pointing to inaccuracies in the reporting of normal charges by doctors to Blue Shield which suggests that existing fee schedules cover substantially more than 82% of doctors' normal charges. In view of this fact, Blue Shield is directed to take appropriate steps to secure full and complete information in this regard and then determine whether the income limits for full-service benefits under both Plan A and Plan B could be raised without any further adjustment of fee schedules. (Underscoring added.)

Conversely, I direct that consideration be given to determine whether a totally revised fee schedule with generally lower fees reflected in lower subscription rates for full-service benefits can be developed for all citizens of Pennsylvania in the lower income groups without regard to their age. Efforts along this line would be in full keeping with the clear intent of the Legislature in permitting the creation of Blue Shield as a nonprofit public-purpose corporation primarily for the benefit of low-income citizens. The problem of paying for medical care is just as burdensome upon a person or family with low income whether the wage earner or his dependents are sixty-five years of age or under.

Society's general acceptance of the doctor's privilege to charge high income patients larger fees for a specific service is based upon society's expectation that doctors will charge low income patients a much lesser fee for the same service. The Insurance Commissioner, who represents the public, can properly inquire and, in fact, is obligated to inquire under the law, whether the Blue Shield rates paid by our low income citizens are providing doctors with fees which only persons with substantial incomes would normally be charged. (Underscoring added.)

H. L. MENCKEN'S PHILOLOGY TO BE REVISED BY DISCIPLE

One of the most widely acclaimed philologic works on American speech is the late H. L. Mencken's *The American Language*. The fourth edition of the work was produced in 1938, and despite two supplements it is now somewhat behind the times.

In order to keep the work a reference book on the current language, Raven I. McDavid, Jr., associate professor of English at the University of Chicago, is revising it and adding a third supplement.

Professor McDavid, who was in close communication with the Sage of Baltimore while he was alive, feels a rather strong obligation to maintain both the quality of Mencken's scholarship and his iconoclastic wit.

In his discussion of the term "Doc," Mencken stated that many of "the non-Hippocratic varieties of leechcraft" have "energetic lobbies seeking, with some success, full recognition as practitioners of healing on a par with orthodox M.D.'s" and that "in some localities 'Doc' is also used as an informal salutation to a stranger."

To these words McDavid adds "... especially one wearing glasses, who is thus distinguished from the unbespectacled stranger, usually addressed as 'Mac'."

Concerning the Ph.D. degree, Mencken wrote: "Even now it is seldom or never given for that congeries of quackeries which is promulgated in American universities, under the title of Education." To tnis McDavid adds: "Nor do English universities offer the subsaline Ed.D. (Doctor of Education) which schools of pedagogics dispense to their inmates too inept for a Ph.D., even in 'education'."

... Reprinted from MEDICAL TRIBUNE, March 13, 1961

SAMUEL ADELSON, M.D.

of Newport, Rhode Island

President of the Rhode Island Medical Society, 1961-1962

PRESIDENT'S MESSAGE

ALMOST one hundred and fifty years have elapsed since the physicians of Rhode Island joined together and formed the Rhode Island Medical Society. The purpose of the organization then was to enable the members to render better medical care to the people of this state and to promote medical progress among the doctors of this state. These aims and purposes are still maintained

Let us pause awhile, look back into the past and meditate on the many changes that have taken place in our profession. Our medical forebears did not have the advanced scientific knowledge, the tools, wonder drugs, hormones, antibiotics, etc. that the medical student now takes for granted.

However, they enjoyed the complete confidence of their patients. They possessed dignity, a deep devotion to humanity, and self-sacrificing dedication to their ideals. They were not hampered by unreasonable governmental restrictions and they distributed healing to all, rich and poor alike. The quality of medical care was good and no one was denied. Public relations was not thought of at all. No special effort was required to foster good feeling between doctor and patient.

Then the government stepped in. The bureaucrats in Washington and in state capitols decided that doctors should be told what kind of care to give and how it is to be distributed. Such interference by government or any other intermediary agency can greatly impair the quality of medical care that Americans are now getting.

In the recent Presidential election year the candidates for office vied with each other as to who could give away more of our natural resources, and they have even bartered away medical services for votes.

There are now in America about fourteen million people over sixty-five years of age. This was found to be a bonanza for votes and these older people were promised among other benefits, free hospital and medical care. The vast majority of these senior citizens have provided for their retirement years by exercising thrift and good management during their working years, by pensions, annuities, health insurance, such as Blue Cross and Blue Shield. They do not need and do not want handouts from the government. They wish to maintain their self-respect and dignity. Only a small percentage need help and this group is now adequately provided through existing agencies.

Medicine is a noble profession, a science and an art, developed through many years of study and practice. It has made greater strides in the past half-century than in all prior recorded history. It has increased longevity of man by about thirty years. It has conquered many dread diseases and it is now on the threshold of yet greater discoveries. All this was attained through private enterprise without government interference.

To maintain the high standard of medical care in America, I reiterate the plea made by Doctor Earl J. Mara one year ago: that you support the Rhode Island Medical Society and the American Medical Association in their stand against the socialization of medicine. These are your organizations. They deserve your wholehearted support for the benefit of the American people.

SAMUEL ADELSON, M.D., *President*

FRANK I. MATTEO, M.D.
of Providence, Rhode Island
Vice President of the Rhode Island
Medical Society, 1961-1962

ARTHUR E. HARDY, M.D.
of Warwick, Rhode Island
President-elect of the Rhode Island
Medical Society, 1961-1962

Editorials

DOCTOR FRANK T. FULTON

On April 10, 1961 Doctor Frank T. Fulton died at the age of ninety-three. This date marks the end of the life of the man who, more than any other person, brought scientific medicine to Rhode Island. In the preface to Doctor Fulton's account of the establishment of the heart station at Rhode Island Hospital, Doctor Levine, says of him, "At Johns Hopkins he came under the influence of those celebrated medical figures, especially William Osler, who made that institution famous. The remarkable thing is that he succeeded in maintaining those high ideals that could more easily be retained in a teaching or university medical clinic, although he settled in Providence where there was no medical school. During the past half-century Doctor Fulton, probably more so than any other single person, has been responsible for the high level of medical practice and what is equally important, the high level of medical integrity that prevails in his community."

He introduced many firsts in the scientific study of patients in this state. The first privately owned electrocardiograph and the first instrument for estimation of the basal metabolic rate were his. By his early work in the systematic study of tuberculosis in factory workers, his studies in the clinical treatment of meningococcus meningitis and in many other applications of the most modern medical methods, he brought the benefits of the best medicine of the day to his community and his state. His observations on auricular flutter were the first published in America.

The establishment of the heart station at Rhode Island Hospital was, beyond a doubt, the accomplishment which gave him the most satisfaction. To this day it is recognized as one of the great training centers in cardiovascular disease.

As a most distinguished representative of Rhode Island medicine, Doctor Fulton received national recognition as a leader in his field. He was the first real internist to practice in Rhode Island and it is fair to say he was the greatest.

THE POLIO PUSH: THERE IS STILL TIME

As this issue reaches our readers time will almost have run out for effective poliomyelitis immunization for the 1961 season. Children who have not yet been immunized should have their series started at once. It is still not too late for those who have already had two, three, or four inoculations in past years to have another. A booster dose for everyone is highly desirable. This is mandatory for children, definitely indicated for those under forty, and of distinct value even for those in the older age groups. A strong campaign should be waged to get all preschool children polio vaccinated as this is the group that has in recent epidemics produced most of the cases, as strikingly exemplified in the Rhode Island epidemic of 1960.

Recent evidence indicates that current supplies of Salk vaccine are highly effective, and earlier deficiencies have been overcome. There is certainly no valid excuse for waiting for oral preparations.

Physicians, hospitals, public health officials, and newspapers should all get behind this final push. There is little time to lose.

I have had my shot; *have you had yours?*

"AN EXCITING TRAIL"

Published in this issue is an outstanding paper titled *Some Biochemical Aspects of Psychiatry* by Doctor Mark D. Altschule of Harvard Medical School, director of the Laboratory of Clinical Physiology at McLean Hospital in Waverley, Massachusetts. Doctor Altschule, a graduate of the Harvard Medical School, a thoroughly trained and experienced internist, and a clinical and laboratory inves-

continued on next page

tigator of considerable stature, has directed these disciplines and his not inconsiderable talents to researches in the hitherto esoteric realm of the psychiatrist. The paper is based upon one read before the Providence Medical Association. The note accompanying the paper upon its submission is a characteristic example of Doctor Altschule's succinct and pungent style: "Here at last is the paper. I believe that it is a better one than I actually delivered."

At an earlier meeting of the Association in January, 1959, (RHODE ISLAND MEDICAL JOURNAL 42:168, 1959) Doctor James A. Watt of the National Heart Institute of Bethesda presented a paper titled *The Pharmacological Revolution*, in which some of this same territory was covered. After discoursing upon some of the then recent advances in brain chemistry and pharmacology, he added: "This would suggest that the vistas opened up by the study of the chemistry of the brain are even vaster than we had believed. Just where this trail that we are now following toward a better understanding of how our minds, our brains, and our senses work might ultimately lead, I can only guess. But I can assure you that it will be an exciting trail to follow." This was most certainly an accurate forecast, as the current brilliant paper will confirm.

WHAT DO YOU BELONG TO?

BROWSING THROUGH a late issue of our distinguished contemporary, the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, we encountered these rather prosaic items: that the New Jersey Proctologic Society had elected its officers for the year 1960-1961, and that the New England Society of Anaesthesiologists planned to hold its annual business meeting at Steuben's Vienna Room, 114 Boyleston Street in Boston (the Athens of America). Reading on we learned that "No scientific program has been planned. Cocktails and dinner will follow the meeting." Then we took note of meetings of the Metropolitan New York Chapter of The American Medical Writers Association, and of The Boston Society for Gerontologic Psychiatry, Inc. In one and the same issue the New York Allergy Society and the International Society of Allergology (a rare mouthful) appeared to be competing for attention. The American Laryngological, Rhinology, and Otological Society, long familiar to its intimates by the cozy nickname of The Triological Society, announces a meeting to be held at the Lake Placid Club. The more simply titled, but self-consciously exclusive, American Surgical Society, announced its current conclave at the plush Boca Raton Club. Then there were announcements of the Aerospace Medical Association, and the Bockus Alumni International Society of Gastroenterology. The Society of American Bacteriologists it was reported had changed its name after sixty-one years of existence to the American Society of Microbiology, effective immediately.

The A.M.A., the fifty state societies (we note the proud listing of the Alaska State Medical Association at Sitka, May 24-27), and the major specialty groups, such as the American College of Surgeons, the American College of Physicians, the American Academy of Pediatrics, and the like, don't begin to encompass the hundreds of formally incorporated medical societies now vying for the doctor's time. Every issue of the J.A.M.A. lists close to three hundred meetings. Many of these organizations have colorful and exotic titles, such as the American Physicians Art Association, the Society for Investigative Dermatology, the Biologic Photographic Association, or the Academy of Psychosomatic Medicine, and there are such others as the International Conference on Medical Electronics, the American Academy of Forensic Sciences, the Southwestern Society of Nuclear Medicine, the Society of Biological Psychiatry, the American Society of Clinical Hypnosis, and the International Conference on Bio-Medical Electronics.

Certain groups seem to have a peculiar geographical slant, such as the Intermountain Pediatric Society, the Italian Society of Gastroenterology, the British Dietetic Association, and most charming of all, the Bahamas Serendipity Conference.

The spawning of societies goes on unabated. A recent issue (January) of the AMERICAN JOURNAL OF SURGERY was devoted to a Symposium on Colon Surgery comprising papers presented at the first annual meeting of the Association for Colon Surgery, held at Miami Beach in June, 1960. The introduction to this issue contained the following thoughts: "The idea for the formation of the new organization has found enthusiastic acceptance among surgeons throughout the country. . . . When a new society is formed there are always *a few persons* (italics ours) who believe that we already have enough societies. . . ." Apparently this defeatist attitude is frowned upon by the writers.

We do not feel impelled to make any profound editorial pronouncements on this subject. We have discovered, however, buried in the avalanche of meeting announcements, one which may be a faint portent of a change to simpler times. We should like to direct attention of our readers to the forthcoming meeting of the International Congress of Practical Medicine to be held in Grado, Italy, June 5-17.

WHERE DO WE GO FROM HERE?

WITHIN A PERIOD of barely forty-eight hours, two hospitals in Providence, the Rhode Island and the Miriam hospitals, have staged research programs in which a total of twelve papers and eleven exhibits on research projects were presented. The scope of these papers was broad, ranging from such esoteric matters as chromosome counting to a new and successful stainless steel stapedial prosthesis designed, fabricated, and first used in this community. This considerable activity is a promising portent of the future.

Doctor Julian Johnson, John Rhea Barton Professor of Surgery at the University of Pennsylvania, remarked during his recent tenure as surgeon-in-chief *pro tempore* at the Rhode Island Hospital that he knew of no non-university hospital with a comparable academic environment, and further asked when Providence, with excellent university and hospital facilities, would have a medical school.

In posing this question he has joined a considerable list of eminent men, such as: Professor William Gammell of Brown University at the opening of Rhode Island Hospital (1868); Doctor Charles W. Parsons, son of Usher Parsons (1881); William Osler ("The money should be the least difficult thing to get in this plutocratic town," 1899); and not the least, Congressman John Fogarty (1960), who has exerted his not inconsiderable influence in federal medical affairs toward this end.

Perhaps before these words reach the light of day, the fateful step will at long last have been taken.

SOCIALISM AND MEDICAL CARE

PROPONENTS OF the proposal to provide federal medical aid to everyone over 65 receiving benefits under social security deny their program would be an opening wedge to socialized medicine. The Socialist party of the United States apparently thinks otherwise.

The Socialists favor complete socialization of medicine, as well as complete socialization of just about every facet of American life. They have just issued a pamphlet which describes a program for bringing about socialized medicine on a bit-by-bit basis. The first bit would be the social security concept of medical aid to the aged.

Norman Thomas, long the major voice of socialism in this country, has made clear the position of his party. He says the bill in question is "insufficient" and a "timid start." But he advocates its support, for reasons which should be obvious to anyone who knows the purpose of socialism—which, by the way, is the forerunner of communism. Mr. Thomas doubtless believes the Chinese proverb which holds the longest journey begins with a single step. And a program of socialization must also begin in a limited way. But the limitations will inevitably grow fewer and fewer as time wears on. If one group — arbitrarily chosen regardless of need — is to have its medical care bills paid for by the federal government, other groups will demand and receive the same handouts. So, little by little, socialized medicine will be brought about.

The Socialist party, its spokesman, Norman Thomas, and the rank and file of the membership have every right to their position. Those who disagree with the position taken by Thomas also have the right, and the obligation to fight Socialist proposals. This is not a matter of denying medical services to elderly persons whose own resources are inadequate. The federal-state co-operation measure passed by the last Congress provides for aid to all who need it, whether they are under social security or not. That is the proper way to meet the problem.

. . . Reprinted from the editorial page of the PAWTUCKET (Rhode Island) TIMES, Wednesday, April 12, 1961.

MINIMUM WAGE LEGISLATION AND THE HOSPITALS OF RHODE ISLAND

LEGISLATION CALLING for a federal minimum wage of $1.15 an hour has passed the House of Representatives in Washington. We understand state legislation will follow the federal pattern. We heard at the New England Hospital Assembly that the Boston hospitals are seriously considering an overall personnel charter for their hospitals which includes a wage floor of $1.15. The question of whether hospitals in Rhode Island will be faced with at least a $1.15 minimum hardly seems worthy of recording. The only point for debate is the question of timing.

Assume passage of some kind of federal minimum legislation during this session of Congress.

concluded on next page

As all hospitals in Rhode Island are on a fiscal year beginning October 1, it may well be assumed that the impact of such federal minimum wage legislation would not be felt in this year's operation. It does mean, however, that such minimum wage legislation would have a full-year impact on the fiscal year we will all be entering October 1, 1961.

What does this mean in terms of hospital costs in Rhode Island? It means that, in addition to the anticipated 5% to 7% increase in cost that has accrued in recent years due to inflationary factors, coupled with rapid advances in medicine, we will have an additional x % increase because of this added payroll cost.

What does this mean in terms of government reimbursement for the care to welfare patients? It means that unless we take some intermediate action, hospitals will be absorbing the full impact of this additional minimum wage legislation for twenty-one months (until July 1, 1963) prior to its being reflected in the cost formula by which the state government reimburses hospitals for service to its accepted patients. With this in mind, should not the Hospital Association of Rhode Island consider a proposal to state government on a payment arrangement to hospitals of Rhode Island concurrent with a change in the federal minimum wage based upon Scovell Wellington and Company's latest cost study, plus an amount projected to cover whatever minimum wage increase is forthcoming from Congress, or a payment formula that would reimburse hospitals on a more current basis?

If such steps are not taken, all hospital income resources, other than government, including the paying patients, will be contributing a far greater share than is usual and proper to the care of welfare cases during this coming fiscal year.

. . . A guest editorial by LLOYD L. HUGHES, deputy director of Rhode Island Hospital, and Trustee, Hospital Association of Rhode Island, published in the Hospital Association's NEWSLETTER, April, 1961.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

THE FIRST MEETING of the year of the Newport County Medical Society took place on March 15, 1961 as a joint meeting of the Newport County Medical Society with the Naval Medical Officers of the Naval Hospital, and the Deslant Fleet, at 8:30 P.M., at the Officers' Club at the Newport Naval Base, with Doctor José M. Ramos, president, presiding.

This was the second meeting of these two medical groups, and it was felt that such an initiative had brought about not only a gratifying feeling of comradeship between civilian and naval medicine but had also sparked a feeling of unity between them which was considered primordial for their future undertakings.

The guests for the evening were: Doctor Joseph L. Yon, commanding officer of the Naval Hospital, as president of the Naval Hospital Staff; Doctor Earl Mara, president of the Rhode Island Medical Society; Captain James Collett, commanding officer, U.S. Naval Station, Newport; Doctor Ernest Joy, chief medical officer of Deslant; Doctor Charles S. Dotterer, liaison officer, between the Newport Hospital staff and the Naval Medical officers; Doctor Charles Smith, the Naval Station medical officer; Doctor Samuel Adelson, president-elect of the Rhode Island Medical Society; Captain William H. Snyder, dental officer, U.S. Naval Station, Newport; Doctor Donald B. Fletcher, vice-president of the Newport County Medical Society; and Captain Jesse Suiton, executive officer of the Naval Hospital.

The speaker of the evening was Professor William Dameshek of Tufts College, Medical School, who spoke on acute and chronic leukemias, from the point of view of both diagnosis and treatment.

The meeting adjourned at 11:45 P.M.

Respectfully submitted,

JOSÉ M. RAMOS, M.D., *President*

LEXICOGRAPHERS PLEASE COPY

Which is a sign of danger, "flammable" or "inflammable?"

Both. They mean capable of being easily ignited.

On the other hand, points out the World Health Organization, the language is full of opposites such as formal and informal, decent and indecent, capable and incapable.

That's why a meeting of the WHO recommends flammable with an opposite non-flammable.

Officers, 1961-1962 — THE RHODE ISLAND MEDICAL SOCIETY

MICHAEL DI MAIO, M.D.
of Providence
Secretary

J. MURRAY BEARDSLEY, M.D.
of Providence
Treasurer

CHARLES J. ASHWORTH, M.D.
of Providence
Delegate to the A.M.A.

SEEBERT J. GOLDOWSKY, M.D.
of Providence
Editor-in-Chief
R. I. MEDICAL JOURNAL

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held on April 19, 1961

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, April 19, 1961. The meeting was called to order by the president, Doctor Earl J. Mara, at 8:00 P.M. The following delegates were in attendance:

BRISTOL COUNTY: Robert W. Drew, M.D. *KENT COUNTY:* Edmund T. Hackman, M.D.; George L. Young, M.D. *NEWPORT COUNTY:* Philomen Ciarla, M.D. *PAWTUCKET DISTRICT:* Edward J. Butler, M.D.; Walter J. Dufresne, M.D.; Francis E. Hanley, M.D.; Robert C. Hayes, M.D., and Earl F. Kelly, M.D. *WASHINGTON COUNTY:* Hartford P. Gongaware, M.D. *WOONSOCKET DISTRICT:* Joseph A. Bliss, M.D.; Saul A. Wittes, M.D. *OFFICERS OF THE RIMS* (other than delegates): Earl J. Mara, M.D.; Samuel Adelson, M.D.; Arthur E. Hardy, M.D., and J. Murray Beardsley, M.D. *IMMEDIATE PAST PRESIDENT OF RIMS:* Alfred L. Potter, M.D. *PROVIDENCE MEDICAL ASSOCIATION:* Robert R. Baldridge, M.D.; John T. Barrett, M.D.; Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Harry E. Darrah, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; Henry B. Fletcher, M.D.; Warren Francis, M.D.; Frank Fratantuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Robert V. Lewis, M.D.; William J. MacDonald, M.D.; Frank I. Matteo, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Jack Savran, M.D.; Carl S. Sawyer, M.D., and Stanley D. Simon, M.D.

The following delegates were absent:

KENT COUNTY: Peter C. Erinakes, M.D. *NEWPORT COUNTY:* Charles Dotterer, M.D. *WASHINGTON COUNTY:* Freeman B. Agnelli, M.D.; James A. McGrath, M.D. *WOONSOCKET DISTRICT:* Edward B. Medoff, M.D. *OFFICERS OF THE RIMS* (other than delegates): Frank W. Dimmitt, M.D. *STATE HEALTH DEPT. DIRECTOR:* Joseph E. Cannon, M.D.* *PROVIDENCE MEDICAL ASSOCIATION:* Bertram H. Buxton, Jr., M.D.; Waldo O. Hoey, M.D.; Walter S. Jones, M.D.; Frank C. MacCardell, M.D.; William S. Nerone, M.D., and John Turner II, M.D. *DELEGATE TO A.M.A.:* Charles J. Ashworth, M.D.*

*Without vote.

Also present were: Doctor Alex M. Burgess, chairman of the Committee on Publications, Doctor Francis B. Sargent, chairman of the Committee on Medical Defense and Grievance, and John E. Farrell, SC.D., executive secretary of the Society.

Doctor Robert C. Hayes, of Pawtucket, reported to the House that the Pawtucket Medical Association had elected as its delegates Doctors Edward J. Butler, Walter J. Dufresne, Francis E. Hanley, Robert C. Hayes, and Earl F. Kelly, but that official notice of their election had not been transmitted to the secretary of the Society.

ACTION: The motion was made, seconded, and adopted that the Pawtucket delegation be seated as delegates with the understanding that official notice of their election be subsequently received by the secretary from the Pawtucket Medical Association. The motion was seconded and adopted.

REPORT OF THE SECRETARY

Doctor Arthur E. Hardy read his report, copy of which was included in the handbook.

Doctor Arnold Porter briefly reviewed the plans for the Health Fair which is to be held in connection with the Sesquicentennial Celebration, and he reported on the anticipated expense for this project.

ACTION: The House of Delegates voted that the Society be empowered to assess up to $20 per member to provide funds to underwrite the cost of the Health Fair in connection with the Sesquicentennial, the assessment to be determined on the basis of funds necessary by the committee to finance the project. The motion was seconded and adopted.

* * *

The secretary reported that the A.M.A. had notified him that it had named Doctor Freeman B. Agnelli, of Westerly, as its key man for legislative liaison between the Society and the A.M.A.

* * *

ACTION: It was moved that the complete report of the secretary as presented be approved and placed on file. The motion was seconded and adopted.

PROPOSED BY-LAW CHANGE

The president noted that a proposed by-law change regarding the composition of the standing committee on Public Policy and Relations had been included in the handbook. Doctor Arnold Porter, chairman of the Committee, briefly reviewed the reasons for proposing this change.

ACTION: It was moved that the proposed by-law change be approved and submitted to the Society membership at the general meeting on May 3. The motion was seconded and was passed without dissenting vote.

* * *

The by-law amendment as approved is as follows: "SECTION 11. PUBLIC POLICY AND RELATIONS. — The Committee on Public Policy and Relations shall consist of five (5) members, of whom three shall be the president, the president-elect, and the secretary of the Rhode Island Medical Society, and two members elected by the House of Delegates. The Committee shall concern itself with all matters of public policy, public relations, and information relative to medicine and public health."

NOMINATIONS FOR OFFICERS AND STANDING COMMITTEES

The president noted that the nominations for officers and standing committees to serve for the fiscal year 1961-1962 were included in the handbook. He asked if there were any other nominations to be made by the House.

The nomination of Doctor Alex M. Burgess to be chairman of the Publications Committee, replacing Doctor Charles L. Farrell, was made and seconded.

A motion was made that the chairmanship of the Committee on Medical Economics be assigned to Doctor Stanley D. Simon. The motion was seconded and adopted.

A motion was made, seconded, and adopted that the list of nominations be closed.

* * *

ACTION: The motion was made that the slate of officers, with the exception of those as chairmen of the Committees on Publications and Medical Economics, be adopted. The motion was seconded and unanimously adopted, and the slate of officers was declared elected.

* * *

The president named Doctors Arnold Porter and William J. H. Fischer as tellers for the written ballot on the offices of chairman of the Committee on Publications and the chairman of the Committee on Medical Economics.

The tellers reported a majority vote of the House was for Doctor Alex M. Burgess as chairman of the Committee on Publications in place of Doctor Charles L. Farrell and Doctor Stanley D. Simon to be chairman of the Committee on Medical Economics.

In accordance with the vote of the House the president therefore declared Doctor Burgess as chairman of the Committee on Publications in place of Doctor Charles L. Farrell and Doctor Stanley D. Simon to be chairman of the Committee on Medical Economics.

REPORT OF THE SECRETARY

The secretary reported he had no communications to present nor resolutions from any district medical societies.

REPORTS OF COMMITTEES

Benevolence Fund

The report of the Benevolence Fund, as presented in the handbook of the delegates, was accepted and placed on file by a vote of the House.

Committee on Blood Banks

The secretary read a report of the Blood Banks Committee as submitted by Doctor Gary Paparo, its chairman. The report was accepted and placed on file by vote of the House.

Committee on Diabetes

The report of the Committee on Diabetes was accepted and placed on file by vote of the House.

Industrial Health

The report of the Committee on Industrial Health was accepted and placed on file by vote of the House.

Library

The report of the Library Committee was accepted and placed on file by vote of the House.

Maternal Health

The report of the Committee on Maternal Health as submitted in the handbook was discussed by members of the House.

ACTION: It was moved that the report of the Committee on Maternal Health be received and that the House request that the committee clarify the medical examiner situation relative to post-mortem examinations and that it inform the members of the Society of its clarification in a future report. The motion was seconded and adopted.

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Medical Defense and Grievance

Doctor Francis B. Sargent reported that the Committee had received but one complaint necessitating investigation by the Grievance Committee in the past three months and that one suit for malpractice had come to trial with a verdict returned in favor of the physician.

The report as presented was approved by the House.

Committee on Medical Economics

Doctor Stanley D. Simon gave an oral report on the investment program for members of the Society which has been developed by the Committee on Medical Economics. He noted that the first day's returns to the Committee's inquiry had indicated an overwhelmingly favorable response to the proposal.

The report as presented was approved by the House.

Physicians Service

The president and several members of the House who serve as members of the Board of Directors of Physicians Service gave an informal report on recent developments of the Physicians Service program involving the extended benefits plan for federal employees.

Committee on Prevention and Treatment of Athletic Injuries

The report of the committee as submitted in the handbook was received and placed on file by a vote of the delegates.

Committee on Publications

Doctor Alex M. Burgess, chairman of the Committee on Publications, briefly reviewed the actions of the committee relative to several mechanical matters including the issuance of reprints, and he discussed what was considered to be the function of the committee. The report as submitted was approved by the House.

Public Laws

The report of the Committee on Public Laws was accepted and placed on file by vote of the House.

Public Policy and Relations

The report of the Committee on Public Policy and Relations was accepted and placed on file by vote of the House.

Science Fair

The report of the Science Fair Committee was accepted and placed on file by vote of the House.

Social Welfare

The report of the Social Welfare Committee was accepted and placed on file by vote of the House.

Trustees of the Medical Library

The report of the Trustees of the Medical Library was accepted and placed on file by vote of the House.

RESOLUTION FOR THE ESTABLISHMENT OF A PHYSICIANS SERVICE REVIEW COMMITTEE

Doctor Stanley D. Simon presented a resolution by which a permanent Physicians Service review committee would be established, and he explained the reasons for the introduction of this resolution. He moved its adoption.

The motion was not seconded.

FEE REVIEW COMMITTEE

Doctor Adelson discussed the interest of the House in the matter of review of the Physicians Service fee schedule periodically, and he moved that the Committee on Medical Economics of the Society consider feasible mechanisms for the establishment of a fee review committee and that it report to the House of Delegates its recommendations. The motion was seconded and adopted.

VOTE OF APPRECIATION

Doctor Earl F. Kelly, a delegate from Pawtucket and a past president of the Society, noted that the meeting was the last meeting of the House over which Doctor Mara would preside as president, and he called for a rising vote of thanks for Doctor Mara's outstanding service as presiding officer at the meetings throughout the fiscal year. The House applauded Doctor Mara with a standing vote of appreciation.

* * *

The meeting was adjourned at 9:40 P.M.

Respectfully submitted,

ARTHUR E. HARDY, M.D., *Secretary*

REPORT OF THE SECRETARY

At a meeting of the Council held since the January meeting of the House of Delegates, the following actions were taken:

1. Reports from the chairmen of the Sesquicentennial Celebration Committee, and the Health Fair Committee, were received, and the Council approved of the proposal for a Health Fair, and it authorized the committee to proceed with the plans for it with a tentative budget of $15,000 to $16,000 which would be provided, if necessary, by assessment up to $20 per member of the Society.
2. The Council received a detailed report of the national legislative conference held in Chicago

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HOUSE OF DELEGATES

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on March 18-19, and it approved of suggestions of the Society's delegates to that conference for publicity to the membership of the Society on the major issues involved.

3. The Council unanimously voted that Miss Grace E. Dickerman, *Librarian Emeritus*, who was librarian when the Society opened its building in 1912, be nominated to the membership at the annual meeting for election to the Society as an honorary member.
4. The Society named Doctor Francis B. Sargent as the official delegate, with legal counsel and the executive secretary, to the Medical-Legal Conference sponsored by the American Medical Association to be held in New York in April.
5. The Council voted that the district medical societies be urged to co-operate fully in the operation of local polio immunization clinic programs when there is a demonstrated need for such clinics.
6. A donation of $50 was made to the National Society for Medical Research to further its activities.
7. Approval was given to the Committee on Industrial Health to conduct a poll of the membership to ascertain what members are engaged in industrial medicine, or are interested in such practice.
8. The Council nominated to the American Medical Association as nominees (one to be selected) as the key legislative representative between the Society and the A.M.A. the following: Doctors F. B. Agnelli, Arthur E. Hardy, and Thomas Perry.
9. The Council voted that a by-law change be submitted to the House relative to the composition of the committee on public policy and information.
10. A report on the proposal for a medical assistants' association in Rhode Island was received and placed on file.
11. The Council voted to dispense with a scientific interim meeting in 1961, and it voted that the Society should join with the Auxiliary in sponsoring its proposed "family day" on Sunday, October 15, at the Anderson Farm in Coventry.

Respectfully submitted,

ARTHUR E. HARDY, M.D., *Secretary*

BENEVOLENCE FUND

During 1960 the Trustees of the Benevolence Fund extended financial aid to three physicians and/or their families. Two physicians died to whom the Trustees had previously given financial assistance.

In addition to financial grants to two physicians during the year, the Trustees also provided these physicians, and the family of another physician, with family Blue Cross and Physicians Service coverage, paid by the Benevolence Fund.

The Trustees express their appreciation to the membership of the Society, the Providence Medical Association in particular, and the Auxiliary for their continued generous support of this most deserving program of the Society.

A summary financial report for 1960 is presented:

Cash balance, Savings Dept., Industrial Nat'l Bank, Providence, Jan. 1, 1960		$ 5,844.07
Receipts, all sources, 1960		5,267.50
Interest on savings account		241.90
Total assets		$11,353.47
Benefits paid:		
In cash to two physicians	$1,000.00	
Blue Cross-Physicians Service coverage (three families)	426.60	
Total		1,426.60
Cash on hand, Savings Dept., Industrial Nat'l Bank, Providence, Jan. 1, 1961		$ 9,926.87

Respectfully submitted,

DAVID FREEDMAN, M.D., *Chairman* (1961)
HENRY J. HANLEY, M.D. (1962)
GEORGE W. WATERMAN, M.D. (1963)

COMMITTEE ON DIABETES

The Diabetes Committee has had an outstanding year.

During our fall Diabetic Detection Drive, probably our best fair ever was held under our hospital rotating policy for greater Providence at the Memorial Hospital in Pawtucket (Doctor Albert Tetreault, chairman). Very successful fairs were initiated at Newport Hospital (Doctor Janis Gailitis, chairman) and at the 455th General Hospital at the new Army Training Center in Warwick (Doctor Peter Erinakes, chairman).

The drive was sponsored by the Rhode Island Medical Society in co-operation with the Rhode Island Diabetic Association; the Rhode Island Heart Association; the Rhode Island Public Health Department; the Rhode Island School of Pharmacy; the Rhode Island School of Podiatry; the University of Rhode Island School of Nursing; the Rhode Island Division of the American Cancer Society; the Health Division of the Rhode Island Council of Community Services; the Hospital Society of Rhode Island; the Rhode Island Tuber-

culosis and Health Association; the Rhode Island Society of Neurology and Psychiatry; the Rhode Island Society of Ophthalmology; the Rhode Island Pharmaceutical Association; the Clinical Laboratory Association; P.T.A. groups; the Women's Auxiliary of the Rhode Island Medical Society; the Rhode Island League of Nursing; and leading drug firms.

We have co-operated with Doctor Thomas H. Murphy and the Rhode Island Department of Health in his diabetes detection surveys in Block Island, South County, and Northern Rhode Island; and with Miss Marjorie Wilbur, R.N. in her industrial diabetes detection program.

The Committee has also co-operated in strengthening the Rhode Island Diabetes Association and the establishment of the Clinical Association with that group.

Our plans are to encompass all of Rhode Island in the diabetic program, not only in the detection drive, but also in a continuing effort throughout the year.

Thanks are especially due to Doctors Louis Kramer, Albert Tetreault, and Mr. John Farrell for giving us the benefit of their energy and experience.

Respectfully submitted,
WILLIAM L. LEET, M.D., *Chairman*

INDUSTRIAL HEALTH COMMITTEE

The Committee on Industrial Health met twice in the fall of 1960 and discussed the present workmen's compensation law as it relates to the reporting of "back injuries." The Committee was willing to recommend, if required, to suggest the elimination of the portion of the law which relates to such presently required (but not done) report.

The Committee also held a seminar or panel discussion at the Cranston Print Works on February 22, 1961, at which about forty persons were present. Nearly every one of this Committee was present and took an active part.

A future panel discussion about another subject relating to industrial medicine will be held in the fall of this year, probably October, and it is possible that the members of the New England Industrial Medical Association will be invited to participate. Arrangements are at present under way for this meeting.

The chairman and two members of this Committee will be present in Los Angeles in the month of April, 1961, attending the annual meeting of the American Industrial Association. We hope to bring back a constructive report.

Respectfully submitted,
STANLEY SPRAGUE, M.D., *Chairman*

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LIBRARY COMMITTEE

The figures in this report speak for themselves. Answers to innumerable questions, bibliographic searches, active participation in librarians' gatherings, loans of books and periodicals, exchanges, gifts, material sent as far as Pakistan, and preparation for the Sesquicentennial Celebration, all serving to show that our institution of learning is increasing in stature. This, mainly, because of the ability and tireless efforts of the librarian, Mrs. Helen DeJong, with the help of the librarian emeritus, Miss Grace Dickerman, and the assistant librarian, Miss Deborah Clarke.

FRANCESCO RONCHESE, M.D., *Chairman*

Report of Librarian

Each year, we plan one or two major projects for the months to come; each year, we fall short of our goal but, bit by bit, we manage to make some progress on the backlog of work. Planning for the Sesquicentennial Celebration was our top priority item for 1960-61 and, although we have failed in our manual labor (the reshelving and polishing mentioned in the last report) we *have* succeeded in locating available material needed for the histories of the societies, state and district. We have searched every cupboard and dusty corner and old records (many handwritten) have been gathered together. All portraits, photographs, clippings and historical mementos have been indexed and the location marked. Our collection of old instruments has been placed in an easily accessible section of the storeroom.

Finding early accounts of the Rhode Island Medical Society presented no problem as we have the original records; the same is true of the Providence Medical Association. One other district society was foresighted enough to store its early reports here. Many records of the other societies have, unfortunately, disappeared and we have had to piece together their histories from occasional newspaper items and accounts published in our medical journals. For this reason, we hereby invite anyone who has early records in his possession to place them in this Library for safekeeping.

The past year has seen considerable activity in the field of Library co-operation. We met with a group of Rhode Island librarians in September, at the invitation of Mr. Stuart C. Sherman, librarian of the Providence Public Library, to discuss library resources in the state at the present time and plans for the future development. In October, the librarian was a member of a panel discussion on *New England Libraries in the Life Sciences* which was part of the program of the Third Annual Meeting of the New England Medical Library Association, held in Burlington, Vermont. In addition to the helpful information gathered at these meetings through the papers and discussion, there is great value and consolation in the informal small talk. It's a comfort to know that someone else has had a nightmare of being buried in an avalanche of the *printed word* and that all libraries, large or small, suffer chronically from shortage of space, staff and time!

The Rhode Island medical librarians published the 4th edition of the UNION LIST OF MEDICAL JOURNALS, in September. Eighteen libraries now co-operate in this venture and Brown University continues, most generously, to print it for us. In addition to our local list, we have contributed to the 1960 CHECKLIST OF PERIODICALS AND SERIAL TITLES CURRENTLY RECEIVED IN MEDICAL LIBRARIES IN THE NEW ENGLAND STATES, compiled by Mr. Harold Oatfield of the Pfizer Research Laboratories in Groton, Connecticut. Thus Interlibrary Loan grows and our physicians receive better service in finding needed reference material.

At the request of the Library of Congress, we sent a list of our small group of manuscripts for inclusion in the NATIONAL UNION CATALOG OF MANUSCRIPTS. The papers of Charles V. Chapin make up our largest collection.

The number of duplicate periodicals stored in the basement has been increasing steadily and we had reached the storage saturation point. With co-operation from the weather (a blizzard) we found a

nice, quiet day to sort and list them. Some of the shelves are now clear with 129 items going to local libraries and 582 items sold to magazine dealers.

These were the larger projects. The daily routine is summed up in the following statistics: We received 498 bound volumes through purchase, review, gift, and conversion by binding; 278 were duplicates and were discarded or given to other libraries. Our present total is 43,123. Our readers numbered 2,499 of whom 1,281 were physicians and 1,218 general public. In addition to the readers-in-the-flesh, we averaged 12.6 requests a day by telephone (only requests for information involving actual use of library reference tools were counted). Circulation included 1,452 periodicals and 417 books; of these, 62 were borrowed from the Davenport Collection. We prepared 329 bibliographies. We are receiving 438 periodicals and serials currently. Our interlibrary loan figures show 394 journals and 50 books borrowed from us; 15 journals and 1 book borrowed by us from other libraries. In addition to actual loan, we have verifaxed six items one of which was sent to Pakistan. We have received 30 single issues of periodicals through the Medical Library Association. 32,217 bound volumes and 4,571 unbound volumes and pamphlets have been catalogued to date.

Again, we want to say "thank you" to our friends of the Library who do so much to help us grow with their generous gifts of journals and books. Specific acknowledgments appear in *On the Medical Library Bookshelves*. And the "we" I have used in this report is not editorial — it refers, not only to the librarian, but, also, to Miss Dickerman who has worked many hours in spite of failing health and to Miss Clarke who works overtime willingly and often, and to the staff of the executive office whose members are always helpful.

Projects for the coming year? We have several but we're going to try to sneak up on them this time! Perhaps, by not mentioning them, we'll feel less White Rabbitlike, watch in hand, late to the Duchess's party!

MRS. HELEN M. DEJONG, *Librarian*

MATERNAL HEALTH COMMITTEE

Three meetings have been held by this committee since our last report — one at the home of Doctor William Reid, one at the home of Doctor Guyon Dupre, and one at the home of the late Doctor John Walsh.

There were fifteen deaths during the year 1960 which is an increase over 1959 when we had only nine deaths. These deaths were reviewed in detail and seven of the fifteen were classified as direct obstetric deaths. The obstetric death rate (commonly known as the maternal death rate) is the number of direct obstetric deaths per 10,000 live births over a period of twelve months. We had 19,306 live births in the state during the year 1960 which gives us an obstetric death rate of 3.6. This is only slightly less than the national average of 3.8 per 10,000. In 1959 our rate was only 2.1. Five of the deaths were voted as preventable which means that this committee still has an important task to perform in helping improve our obstetrics in the state.

One problem that we have encountered particularly during the past year is in determining the exact cause of death in these cases. In 1956 the state ruled that all maternal deaths have to be reported to the medical examiner. There were four cases this year which were reported to the medical examiner, and the death certificates were signed by him without an autopsy. These cases were questionable cases of sudden death with which the committee was not completely satisfied as to the diagnoses. We have communicated with the attorney general regarding this problem and hope to have better co-operation in this matter in the future.

To the best of our ability, the causes of death were grouped and classified as follows:

Direct Obstetric Deaths:

1. Traumatic rupture of the uterus
2. Amniotic fluid embolism
3. Postpartum hemorrhage due to uterine atony
4. Tubal pregnancy with pulmonary embolism
5. Abruptio placenta with post-operative shock
6. Cerebral hemorrhage
7. Cardiac arrest

Indirect Obstetric Deaths:

1. Suicide
2. Rheumatic heart disease with cardiac arrest
3. Subacute bacterial endocarditis
4. Pneumonia

Non-related Deaths:

1. Acute mastoiditis with rupture of brain abscess
2. Porphyrinuria
3. Epilepsy
4. Hodgkin's Disease

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The committee would like to express its appreciation to those members who acted as hosts for our meetings this past year. Our last meeting was held at the home of the late Doctor John Walsh on February 28, 1961 where we enjoyed, as we have at many meetings in the past, his usual wonderful hospitality. His sudden passing will be a great loss to this committee which he had served on since its inception in 1931. When Doctor Brackett retired, Doctor Walsh became chairman and continued in this office until he resigned the chairmanship in 1956. The Rhode Island Medical Society has suffered the irrevocable loss of one of its most capable and nationally known obstetricians. His dynamic, positive, and progressive personality was a stimulus and example to all of us. He will be greatly missed by this committee.

Respectfully submitted,
STANLEY D. DAVIES, M.D., *Chairman*

PREVENTION AND TREATMENT OF ATHLETIC INJURIES

This newly formed Committee on Prevention and Treatment of Athletic Injuries had its initial meeting at the Medical Library on Monday, February 27, 1961, with the following members in attendance: Doctors A. A. Savastano, chairman, G. Edward Crane, Edwin B. O'Reilly, and William J. Schwab.

At this meeting the purpose and function of the newly appointed committee was discussed and it was agreed that a preliminary meeting should be held with representatives of the Rhode Island Secondary School Principals' Association to determine what topics should be discussed at a sports injury conference. It was also suggested that the Football Coaches' Association, the school physicians, and the supervisors of athletics be alerted to the plans of the conference when it is formulated.

A second meeting was held on March 13, 1961 with the following in attendance: *Committee of the Rhode Island Medical Society* — Doctors A. A. Savastano, chairman, G. Edward Crane, William J. Schwab, Edwin B. O'Reilly, and Salvatore Turco; *Committee on Athletics of the R. I. Secondary School Principals' Association* — Mr. Joseph P. Delaney, chairman, Hope High School; Mr. C. Herbert Taylor, superintendent of schools, Cranston; Mr. William Kutneski, assistant principal, Cranston East High School; Mr. William Falk, Hope High School; Mr. Edward F. Mullen, Hope High School, and Mr. John F. Cronin, Department of Recreation. Also present was Doctor Adrien Tetreault, school physician of Pawtucket, and John E. Farrell, SC.D., executive secretary of the Society.

At this meeting the group unanimously agreed to hold a one-day symposium on the prevention and treatment of athletic injuries and permission was to be obtained from the Providence College authorities to use the gymnasium at said College. It was further agreed that we would like to hold the symposium on Monday, September 11, 1961. The conference would start at 1:00 P.M., continue through the afternoon, recess for the evening meal, and then resume for an evening session.

Subsequently, definite permission was obtained from Providence College to hold the conference in their gymnasium and Doctor Michael Walsh, commissioner of education for Rhode Island, has also agreed to excuse from their afternoon commitments the members of the Rhode Island State Public School Systems eligible to attend the meeting.

The Committee is scheduled for another meeting on April 20, 1961 at the Medical Library at which time a program schedule will be set up for the subjects to be discussed at the September meeting.

As things now stand we expect to invite all secondary school athletic directors, coaches, trainers, physical education instructors and school physicians.

Respectfully submitted,
AMERICO A. SAVASTANO, M.D., *Chairman*

PUBLIC LAWS COMMITTEE

Please accept this report concerning the activities of the Committee on Public Laws for the Legislative session of the Rhode Island legislature in the Spring of 1961.

The committee met with Mr. John Farrell, executive secretary, who had reviewed proposed legislation submitted to the 1961 session of the Rhode Island General Assembly, that has any bearing upon medicine, in particular or in general.

The legislation thus far proposed covered a wide range of subjects. The legislation already enacted were: the changing of the name of the State Curative Center to Doctor Donley Rehabilitation Center; a bill memorializing Congress of the United States to enact legislation of the Forand Type; a bill concerning a resolution upon the death of Doctor Arthur H. Ruggles; and a veterans' bill which was a resolution opposing efforts to diminish

services to veterans at several United States Veterans Administration hospitals.

Studied by the committee were bills on the basic science, aid for the blind; bloodmobile; Blue Cross-Physicians Service; cancer; civilian defense; consumers' council; evidence; health insurance; public assistance; physicians' lien; social workers; veterans; workmen's compensation that included occupational deafness; employers; medical services and rate reports. These bills were studied and recommendations were made pro and con on many of the bills. Inasmuch as these bills now go to the various committees of both the House and Senate, the various recommendations made were sent to each chairman of each committee and to each individual member of each committee, specifying the reasons why our committee were either for or against the various types of legislation that are being proposed.

A copy of our recommendations is filed with the executive office and they are available for inspection by any member of this house, or by any member of the Rhode Island Medical Society who desires to comment upon them.

Governor John Notte was also furnished with copies of this committee's reports on legislative proposals.

Respectfully submitted,
FREEMAN B. AGNELLI, M.D., *Chairman*

PUBLIC RELATIONS COMMITTEE

During the year press releases were issued by the executive office following actions taken by the Society on various matters of public interest, such as polio immunizations, report on insurance coverage for the aged in Rhode Island, etc. Due to the fact that the various committees from time to time take action on matters of general public interest, it is necessary that public information be given promptly, and therefore this work has not been subject to action by the Committee on Public Policy.

In view of this situation recommendation has been made to the Council that the personnel of the committee, and its assignments be reviewed, and possibly changed to allow it to function as a working committee.

On the broad public information front the committee has aided in several projects involving television, radio and motion picture releases. The Committee co-operated with the Auxiliary in its very successful television programs that were well received.

The radio disks of the A.M.A. releases known as *Medical Milestones* were distributed to five radio stations, and they were used by three, all of whom commented favorably on the presentations.

A.M.A. motion pictures were publicized as available to schools, clubs, etc., and reports indicate that such films as *Helping Hands for Julie, Medicine Man, Whitehall 4-1500, I Am A Doctor, Even for One,* and *A Life to Save,* were shown at schools in Narragansett, Pawcatuck, Woonsocket, Cranston, Providence, Charlestown, and also at several grange and civic club meetings.

Respectfully submitted,
ARNOLD PORTER, M.D., *Chairman*

SCIENCE FAIR COMMITTEE

The 1961 Rhode Island Schools' Science Fair, again held in the Marvel Gymnasium at Brown University, continued to maintain the excellence of displays that has marked this exhibition in recent years.

Your committee spent a good part of Easter Sunday viewing the many exhibits, and its decisions on the six winners, three from senior high schools and three from junior high schools, were as follows:

Senior High Awards

1. Carol Ann DeAngelis of St. Patrick's High in Providence
   Exhibit: Digestive System of Animal Phyla
2. Mary E. Flannagan of St. Teresa's High, Providence
   Exhibit: Visual Version
3. Arlene E. Antonian, St. Mary's Academy, Riverside
   Exhibit: The Structure of Chromosomes

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Junior High Awards

1. Peter S. Arnold of Lincoln Junior High, Cumberland
   Exhibit: Heart-Lung Machine
2. William Darby, St. Teresa's Junior High, Pawtucket
   Exhibit: Our Life-Giving Stream
3. Charlene Miga of Burrillville High
   Exhibit: Beef Tapeworm

* * *

The winners named by the Society will be presented award certificates and a $25 U.S. Treasury bond at the evening session of the 150th Annual Meeting of the Society, at the Medical Library, May 2, 1961.

Respectfully submitted,
JOHN F. W. GILMAN, M.D.
LELAND W. JONES, M.D.
CHARLES L. YORK, M.D.

SOCIAL WELFARE

(Continuing Report — January, February, March, 1961)

The Committee met in February with Mr. Albert P. Russo, new director of the state department of social welfare, who said that the basis of all activities of his department would be for close co-operation with the medical society, and in particular with the committee on social welfare. The committee commented on the appointment of medical personnel without consultation in any manner with the medical society, and it noted that the president of the medical society had been given assurance by the Governor that the Society would be informed of any proposed medical change or appointments.

It was suggested in view of medical appointments made by the state government of out-of-town personnel when it seems that there are capable and qualified people within the state and if suitable compensation is the sole deterrent then the state government should seek realistic wage payments for medical and allied personnel and that the medical society would co-operate with such a proposal in every way possible.

The news release quoting the Governor as opposed to the Kerr-Mills legislation already enacted by Congress, without comment on the fine co-operation of the pooled fund of the division of public assistance, drew comment from the committee.

The matter of drug costs for welfare patients was again reviewed. The Committee expressed approval of a letter received from a drug company relative to a 10% refund for prescriptions for welfare patients provided that no physician would be required to prescribe only from one company, and that the Division of Public Assistance would seek to get all the major pharmaceutical companies to make the same refund arrangement.

On March 1, a new punch-card system utilizing IBM equipment for payment of medical services and supplies provided eligible recipients of public assistance was put into operation. It is hoped that this new system, developed after 18 months of study, will bring a real improvement on the previous method of processing bills.

Because of the attitude of many of the welfare recipients, their failure to call upon doctors at their offices, and their demand for house calls that are not emergency in nature and because the Medical Bureau of the Providence Medical Association is encountering increasing difficulties in servicing calls a conference was held, and a new approach to the problem was evolved. Each welfare recipient's call to the Medical Bureau will be recorded and followed through by the physician answering the call. The recipient without a family doctor will be urged to obtain his own physician, and to be instructed that he must follow the advice of his physician. Failure to act in a responsible manner shall be handled by the Welfare Department. After a three-months' education program, the results will be studied by the Committee and the Welfare Department for further improvement and action.

Respectfully submitted,
PETER L. MATHIEU, JR., M.D., *Chairman*

BOARD OF TRUSTEES OF THE LIBRARY

The extensive repairs to the Library building in 1960 has prompted the postponement of any projected major improvements to the interior of the building for this year. However, within the allocated budget for repairs the necessary improvements have been carried out.

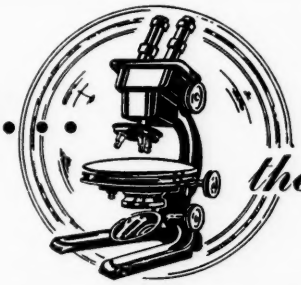
The winter storms created a roof problem in that a sizable fissure appeared unexpectedly over the auditorium section of the Library, resulting in water seepage into the building. The roof was immediately repaired, and in addition a copper covering for access to the loft from the roof is to be replaced as it was discovered to be in poor condition.

The water damage to the ceiling and wall of the auditorium, and reading room will be corrected by painting within the next month. In addition, the interior window sash in the main reading room will be painted.

Necessary repairs to the sidewalk from erosion will also be completed.

Respectfully submitted,
FRANK W. DIMMITT, M.D., *Chairman*

THROUGH . . . the Microscope



American College of Obstetricians Inducts Five Rhode Islanders

At its tenth anniversary meeting held in Bal Harbour, Florida, last month the American College of Obstetricians and Gynecologists inducted 473 new Fellows among whom were five Rhode Islanders: Doctor George W. Davis of Edgewood, Doctors George W. Anderson, George A. Ernst, and John T. Hogan, all of Providence, and Doctor Ernest L. Dupre of Woonsocket.

District 1 chairman for this year is Doctor C. Lee Buxton of Yale University School of Medicine, and the section chairman for Rhode Island is Doctor Frank I. Matteo, vice president of the Rhode Island Medical Society, with Doctor Stanley Davies of West Warwick the vice chairman. The next district meeting is scheduled for Boston on October 5-7.

Blue Shield Plans Pass 47-Million Member Mark in 1960

Enrollment in the nationwide Blue Shield Plans surpassed the 47,000,000 member mark at the end of 1960, the National Association of Blue Shield Plans reported in Chicago recently. Total membership in the 74 medical-surgical Plans reached 47,084,988 on December 31, 1960, representing an enrollment of one out of every four Americans, and nearly 15 per cent of the total Canadian population.

The net gain in membership for 1960 amounted to 2,292,065, the national association noted in its year-end report. The national Blue Shield totals for the first time included the membership of Surgical Service, Inc., Albuquerque, New Mexico, and Physicians Service, Providence, Rhode Island, who were approved as active members of the National Association of Blue Shield Plans last year. The combined year-end enrollment of these two new Blue Shield Plans was 659,240 members. Also included in the enrollment figures were federal workers who selected Blue Shield under the Federal Employee Health Benefit Program in 1960.

Four statewide Blue Shield Plans registered impressive enrollment gains over the twelve-month period. California Physicians' Service, the Blue Shield Plan headquartered in San Francisco, added nearly 192,000 members during 1960, while Texas Blue Shield registered a net gain of more than 185,000 members, and Massachusetts Blue Shield added almost 140,000 members and New Jersey Blue Shield 126,000 members.

The national association also reported that four Blue Shield Plans have enrolled more than 60 per cent of the population in the areas they serve. They are the Plans serving the District of Columbia, Rhode Island, Delaware and Rochester, New York, areas.

House Committee Supports Social Security Increase

The House Ways and Means Committee on March 27 approved a scaled-down version of President Kennedy's plan for higher social security benefits. . . . The vote was 22 to 2. . . . The plan would boost cash benefits this summer for 3,675,000 persons under social security. . . . It also would permit male workers to retire at age 62 and draw permanently reduced cash benefits. . . . The social security tax, now 6% (3% employee, 3% employer) on a tax base of $4,800 would be raised to 6¼% (3⅛% employee, 3⅛% employer). . . . Kennedy originally had proposed tax increases of double these amounts, effective January 1, 1963. . . . The committee decided to advance the date of the increase to January 1, 1962. . . . The increased benefits include: (a) a boost of 10% in cash benefits for widows of deceased workers; (b) an increase from $33 to $40 in the minimum monthly benefit. . . . During the first full year, the increased benefits would cost close to $850 million. . . . The Kennedy plan would have cost a little over $1 billion annually in the early years. . . . This is the bill on which it is rumored the Administration may tag on the compulsory social security aged medical care program.

Who Knows Better Than the Socialists?

The Communist party of Illinois has recently distributed a brochure titled *The Forand Bill Can Be Won Now!* This brochure, under the subtitle

continued on next page

The Forand Bill is the Minimum indicates the future aims of the Illinois communists. The virtue of the Forand Bill is that it is a federal, rather than a state aid measure, and is built into the Social Security system. With all its present limitations the Forand Bill opens the door toward complete hospital, medical and surgical services for the aged, and ultimately for the whole population. It can be enacted at once by this session of Congress.

The December 1, 1960 supplement to *New America*, the official publication of the Socialist party, is devoted to the support of the Forand bill and its extension to everyone in the United States. This publication says in part, "The Forand bill's limitations will be only the limitations of Social Security itself — which, though important, do not subtract from the precedent this bill will establish . . . the Forand bill will not be paid for on insurance principles, according to factors of estimated 'risk.' It will be paid for through the tax mechanisms of Social Security — that is, Americans will pay according to their means, and receive (within limits) according to their needs. . . . Once the Forand bill is passed this nation will be provided with a mechanism for socialized medicine, capable of indefinite expansion in every direction until it includes the entire population. And it is already evident that there will be massive pressures in favor of such expansion."

The American Medical Association has been called "alarmist," among other things, for their insistence that Forand-type legislation is a step in the door to socialized medicine. This is no longer a matter for debate. This type of legislation is socialized medicine for those persons it would cover and would lead to the eventual socialization of the entire practice of medicine. WHO SHOULD KNOW BETTER THAN THE SOCIALISTS?

Disaster Medical Care Conference in New York on June 24

Defense Training for All — A resource for National Defense has been set as the theme for the ninth annual Conference on Disaster Medical Care in New York City, Saturday, June 24.

Sponsored by the American Medical Association's Council on National Security, the theme of the one-day meeting at the Statler-Hilton Hotel will be developed by the United States Air Force Medical Service.

Following opening remarks by Doctor Leonard W. Larson, Bismarck, N.D., A.M.A. president-elect, Major General O. K. Niess, surgeon general of the Air Force, will discuss the adaptability of military medical experience, research, and operations in civilian disasters.

The morning session, under the general heading, *The Problem*, will include discussions on nuclear war and your community, the value of training and exercises, transportation of the injured, and communications. A symposium titled *Organizing Community Resources* will portray the civil defense plans and activities of a local mayor, police and fire chiefs, professional health representatives, and other local groups.

Meeting the Problem will be the general topic for consideration at the afternoon session. Specific subjects for discussion are radiation fallout detection and monitoring; evaluating homes, buildings and other shelters; rudiments of universal first aid training; and techniques for survival — water, food, clothing, shelter improvisations.

Other program subjects will be presented on mass behavior patterns in disaster; legal obligations, public laws, martial law; moral obligations in disaster; and defense planning — a corporate effort for survival.

An interesting feature of the program is a one-hour skit on *Community Responses to Disaster*.

Persons desiring to attend the conference should write to the A.M.A. Council on National Security, 535 N. Dearborn St., Chicago 10, Ill. for additional information and advance registration.

Retired Federal Employees Eligible for Health Benefits July 1

The Civil Service Commission has announced approval in principle of the benefits structure and premium costs of the Uniform Plan to be offered retired Federal employees and survivor annuitants under the Retired Federal Employees Health Benefits Act which becomes effective next July 1. Details of the plan will be worked out during contract negotiations.

The Uniform Plan offers eligible annuitants the choice of enrolling for basic coverage alone, for major medical coverage alone, or for both. Annuitants will not have to meet any age or physical requirements for coverage under the Uniform Plan. The basic coverage will pay benefits in each calendar year of up to $15 a day for 31 days of hospital room and board, up to $150 for other hospital expenses, and benefits in accordance with a fee schedule for surgical charges. Because the individuals expected to be covered under this plan are, in general, in the upper age bracket, maternity benefits are not provided.

The major medical coverage will help pay for room and board charges for additional days in a hospital or convalescent hospital. After a deductible is met, the plan will also help pay for the additional costs of other hospital expenses and surgery. Further, it will help to pay for in-and-out-of-hospital charges for physicians' services, drugs and medicines, and special nursing. The major medical coverage has a $5,000 lifetime maximum for each annuitant and for each member of his family.

The Commission said that the offer of this type

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THROUGH THE MICROSCOPE

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of major medical coverage — which includes benefits for out-of-hospital expenses — to a large group of already retired employees represents a breakthrough in providing health insurance for older persons. Providing benefits for room and board and skilled nursing care in a convalescent hospital is also a move forward in this area. This will help to pay for the kind of specialized care often needed by older persons after the acute stage of an illness.

The cost of the basic coverage will be $6.50 a month for self only and $13 for family enrollment. The major medical coverage will cost $6 a month for self only and $12 for family enrollment. The combined basic and major medical coverages will cost $12.50 a month for self only and $25 a month for family enrollment. Regardless of which of these three choices — basic, major medical, or both — the annuitant elects, the government will contribute $3 a month for self only and $6 for family enrollment. The annuitant will pay the remainder of the premium through deductions from his annuity check. Thus, the annuitant may obtain both basic and major medical coverages at a monthly cost to him of $9.50 if he covers himself only or $19 if he covers himself and family.

The Commission emphasized that any eligible annuitant may elect not to enroll in the Uniform Plan but instead to retain or acquire coverage offered through a qualified private plan. In this case the government contribution of $3 a month for self-only enrollment and $6 for a family enrollment will be made toward the cost of the private plan. The contribution will be paid to the annuitant by increasing his monthly annuity check by the appropriate amount.

The new program offers retired federal employees and survivor annuitants an opportunity to obtain the kind of health insurance coverage which best fits their needs and their pocketbooks, according to Andrew E. Ruddock, director of the Bureau of Retirement and Insurance which is administering the program for the Commission.

"Annuitants who may have been unable to buy health insurance coverage because of advanced age or health status may now obtain it through the Uniform Plan," he said. "Those who have been unable to afford health insurance can now in most cases acquire some protection, because the government will help to pay the cost. Annuitants who have had only basic coverage in a private plan may, if they wish, keep that coverage and in addition buy major medical coverage through the Uniform Plan. Of course, an annuitant who elects a combination of private and Uniform Plan coverage will still receive only one government contribution."

The first-year cost of the program to the government is estimated at from $15,000,000 to $25,000,000 depending upon the extent of participation.

Professional Unionists Get Top Federal Jobs

The list of former professional unionists now holding down top government executive posts in the new Administration continues to grow. Among recent appointees have been Jack Conway, administrative assistant to Reuther, to be deputy administrator of the Housing and Finance Agency; Hyman H. Bookbinder, AFL-CIO legislative representative, to be a special assistant to Secretary of Commerce Hodges; Charles F. MacGowan, international representative of the Boilermakers Union, as director of the Office of Saline Water of the Interior department; and Mrs. Dollie L. Robinson, veteran staffer of the Clothing Workers and government employee unions, to be assistant director of the Women's bureau in the Labor department.

... From the WASHINGTON LABOR WHIRL issued by the Chamber of Commerce of the United States.

"No Consultation Day" in Japan

On February 19, 1961, the Japan Medical Association and the Japan Dental Association sponsored a "No Consultation Day" in order to direct attention of the population to the fact that in spite of a Four-Point Plan submitted by the Japan Medical Association to the Ministry of Welfare, the Ministry continued to ignore the needs and recommendations of the doctors of Japan.

Under the Japan health insurance plan the medical fee is recognized to be the lowest in the world. For example a surgeon receives $9.00 (U.S.A.) for a cataract operation. Hence the Japan Medical Association had requested that the Welfare Ministry: (1) Release medical care under health insurance from restrictions; (2) Increase the medical fee at least 30%; (3) Decrease the annoying business routines associated with health insurance; (4) Simplify the medical fee system by abolishing the current dual system and providing for differential fees according to area.

The recent strike of hospital employees had forced the Welfare Ministry to recommend diet approval of an average increase of 14% for hospitals and 6% for clinics. This irrational discrimination between hospitals and clinics and the failure of the leaders of the Liberal Democratic party to reach an agreement with the medical and dental association representatives in spite of the fact that the special committee on medical care of the Liberal party had endorsed the J.M.A.'s Four-Point Plan and criticism of the Japan Medical Association by the Ministry of Welfare, inspired the "No Consultation Day" demonstration. Doctors and dentists declined to accept consultations but provided emergency care for those who required it and had an

adequate medical staff at hospitals and clinics. The doctors distributed pamphlets and held public relations meetings and press conferences on that day in order to inform the population as to the actual status of the medical care system.

The Japan Medical Association further announced a second "No Consultation Day" would be held on March 5th and that on April 1, 1961 the doctors would withdraw their services from the health insurance plan.

Late in February at joint meetings between political leaders and representatives of the doctors and dentists, some progress was achieved toward solving the problem. The second "No Consultation Day" and the withdrawal from the insurance plan was canceled pending further negotiations with the government.

However, the Japan Medical Association continues ready to effect *No Consultation Days* and to withdraw from the health insurance plan in the event that the government fails to give prompt and just consideration to the problems of the Japanese doctors.

A.M.A. New York Meeting a "World's Fair" of Medicine

The American Medical Association's 110th annual meeting, the *World's Fair of Medicine*, will bring an estimated 50,000 persons, including 25,000 physicians, into New York City, June 25-30.

The five-day convention, biggest of its kind in the world, will attract not only doctors, but also their wives and families as well as residents, interns, exhibitors; in fact, people connected with all the allied fields of medicine. Hence, the convention theme: *Teamwork in Medicine.*

The 1961 meeting will mark the eighth time that the A.M.A. has met in New York. The last convention there was in 1957 when 23,888 physicians registered.

Technical exhibits, numbering 827 and displaying everything from medical books to diapers, and more than 350 scientific exhibits largely developed, designed, and manned by physicians reporting their research, will take up practically every inch of space on all four floors of New York's big Coliseum.

Millions Have Three Health Coverages

More than 120 million Americans are protected by three different kinds of health insurance against the economic consequences of ill health, the Health Insurance Institute reported recently.

"At least two thirds of the nation's civilian population have achieved a substantial degree of financial security by protecting themselves with health insurance policies that help pay hospital and surgical bills, and help replace income lost due to disability caused by illness or injury," said the Institute.

As of the beginning of 1960, the Institute estimated that 132 million persons had hospital expense insurance, 120 million persons had surgical expense insurance, and 43 million workers—through formal plans—had their earnings protected by loss-of-income insurance. Millions of other workers had some degree of income protection through informal arrangements.

According to the U.S. Bureau of the Census, the size of the average family in the United States is 3.7 persons. The Institute calculated that, at a minimum, the 43 million breadwinners with loss-of-income coverage were assured of a continuing income that would provide the necessities of life for some 130 million persons.

The Institute also said that millions of Americans have additional health insurance protection against the cost of doctor calls and other nonsurgical care by physicians. Included in this group are the estimated 86 million persons who have regular medical expense insurance.

Protection against the cost of hospital and surgical bills, and nonsurgical care by physicians is packaged together, said the Institute, in one type of health insurance, major medical expense insurance, which also provides benefits for medicines and drugs, medical appliances, private duty nursing, and ambulance service.

Major medical, little more than ten years old, now covers some 25 million persons.

THE WASHINGTON SCENE

A Report Prepared by the Washington Office of the American Medical Association

THE SERIOUSNESS of the national problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the over-all problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past ten years but that the need for adequate facilities for humane, healing treatment of the mentally ill is still largely unmet.

More than half of the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels — federal, state and local — for public mental patient services be stepped-up in the next decade from the present $1 billion a year to $3 billion a year.

Another recommendation was that there be a fully staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing every national association and nongovernment agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

The government advisory committee, composed of twelve state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services."

Doctor Luther L. Terry, surgeon general of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Doctor Winfred Overholser that there is no foundation to charges that many Americans are "railroaded" into mental hospitals. Doctor Overholser is superintendent of St. Elizabeth's Hospital, large federal mental institution in Washington, D.C.

Doctor Lauren H. Smith, vice chairman of the A.M.A.'s Council on Mental Health, told the subcommittee that the A.M.A.'s future program in the field will include emphasis on more use of psychiatry in geriatrics, pediatrics and medical education, both at student and postgraduate levels.

Other activities planned for the A.M.A. program include closer co-ordination of activities of the A.M.A. council and corresponding committees of state medical societies.

* * *

The Food and Drug Administration, after the government filed suit against two drug firms for counterfeiting, reported that an extensive investigation showed that there is still relatively little counterfeiting of drugs.

Of 2,700 samples of drugs collected from 900 drugstores in the first three months of this year, only nine were found to be counterfeit.

FDA Commissioner George P. Larrick said he expected the problem of counterfeit drugs to continue because of the lure of easy profits. But he said results of the investigation supported the FDA view that "the facts to date do not warrant disturbing sick people about the quality of medications that they have been taking."

In the counterfeiting suit, General Pharmacal Co., Hoboken, N.J., and Lowell Packing Co., Long Island, N.Y., and eight officials of the two firms were charged with manufacturing counterfeit tranquilizers, diuretics, weight reducers and other drugs and selling them to drugstores in six states. The Justice Department charged that the companies put markings on pills making them appear like other trade-marked brands.

* * *

FDA ordered manufacturers, effective May 27, to supply samples of new drugs for testing by the government agency prior to clearance for sale.

In the past, the FDA has relied largely on scientific data supplied by the manufacturers themselves in clearing a new drug as being safe for sale. The FDA tested the drugs only on a limited and occasional basis and after they had been put on the

market.

* * *

The government is spending $4.1 billion a year in the health field, a Senate Government Operations Subcommittee reported. In the most detailed report of its kind ever published by a governmental group, the Subcommittee, headed by Senator Hubert H. Humphrey (D., Minn.), noted that $1.1 billion of the total cares for sick members of the armed forces and their dependents in hospitals. The tab for Civil Service workers' sick leave totals $315 million a year. About $650 million a year is spent on medical research, with most of this carried out by the National Institutes of Health and the Veterans Administration.

* * *

The government ordered 250 physicians drafted this year due to the failure of enough interns to sign up for military service. It is the first physicians' draft in four years. All the draftees will be assigned to the Air Force. A department spokesman said the draft call would not prevent individual physicians finishing internship this year from volunteering for Air Force medical duty.

Legislative Roundup

House Passes Bill . . . The House on April 20 overwhelmingly passed the Administration-backed bill liberalizing social security benefits. . . . The Social Security Administration estimated that an additional $780 million in benefits would be paid out to 4,420,000 people during the first year under terms of the bill. . . . Major provisions of the bill are: (a) allows men to retire at 62 and draw smaller social security benefits than they would get if they waited until 65; (b) increases minimum benefits from $33 to $40 a month; and (c) raises benefits for aged widows, widowers, and parents 10%. . . . Originally called the "Road to Recovery Program," this bill marks the first time since the social security program was launched that Congress has acted to liberalize benefits in a nonelection year.

The End-Around . . . The House bill now goes to the Senate, where the proponents of the compulsory social security approach to health care of the aged may attempt to tack on a medical care amendment to this bill. . . . This "end-around" maneuver, if carried through successfully in the Senate, would mean that the amended bill would then go to a Senate-House Conference Committee. In this way, the proponents of the social security approach would avoid a battle in the House Ways and Means Committee on the bill introduced by California Democrat Cecil King (HR 4222). . . . It is interesting to note that President Kennedy told his news conference today he was not reconciled to the prospects of no vote in Congress this year on his medical care plan. At the same time, he conceded that a vote in the House this year was doubtful. . . . The House Ways and Means Committee has scheduled two weeks of hearings on the President's new tax proposals. . . . The hearings will begin May 3, and at least two additional weeks of executive hearings are expected. . . . Thus, the committee probably will not take up HR 4222 until at least June 1.

Accuse Ribicoff . . . Doctor F. J. L. Blasingame, A.M.A. executive vice president, accused HEW Secretary Abraham Ribicoff of making "false and misleading statements" in calling for support of the Administration's medical care for the aged bill. . . . Doctor Blasingame, in a statement issued April 18, declared that Ribicoff is misleading the public when he says the bill does not include physicians. . . . He said: "The bill definitely includes physicians. It includes interns, residents, and those physicians serving in hospital outpatient clinics. It also specifically includes pathologists, radiologists, psychiatrists, and anesthesiologists working in the hospitals. . . ." Doctor Blasingame asserted: "We think it's high time that Mr. Ribicoff, who occupies a position of enormous trust, began to shoot square with the citizens of this country and quit hiding the truth about medical care for the aged behind political sloganeering. . . ." Doctor Blasingame made his statement after Ribicoff, in a TV interview taped for New York stations, accused the A.M.A. of using "scare tactics" in fighting the Administration's program on medical care.

Expand Kerr-Mills . . . The Senate approved the Administration's program for aid to dependent children of unemployed parents, which contained a provision expanding the Kerr-Mills program. . . . The medical provision, which was proposed by Senator Robert S. Kerr (D., Okla.), increases from $12 to $15 a month the ceiling on state programs in which the federal government could help with matching funds for old-age assistance recipients. . . . Kerr said the $3 increase is needed to bring the welfare medical program closer to actual costs.

Check the date . . .

Monday, Sept. 11, 1961

SPORTS INJURY CONFERENCE

1:00 P.M. to 9:30 P.M.

at

Providence College

Under the Auspices of the

Committee on the Prevention and Treatment of Athletic Injuries

of the

Rhode Island Medical Society

Conference open to all Physicians in Rhode Island, Secondary School Coaches, Trainers, Athletic Directors and Allied Personnel

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